



ER

The New York  
Academy of Medicine



*By Exchange*











Digitized by the Internet Archive  
in 2016

<https://archive.org/details/journalofmedical692unse>



BALCONY

the

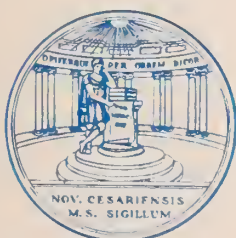
# JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

---

## contents

Pages 585 to 628  
and  
Pages Tr 1 to Tr 144



### EDITORIALS

Who Needs the AMA?	601
Research Starts with Clinicians	601
Thrust, Dialogue, and Nitty-Gritty	601
Medical Leadership in Geriatrics	602

### TRANSACTIONS OF THE HOUSE OF DELEGATES

Index	Tr 3
Annual Reports	Tr 5
Resolutions	Tr 105
Reference Committees	Tr 127
Nominations and Election	Tr 144

### ANNUAL MEETING

Dinner-Dance	615
The Auxiliary Year	623
Attendance	625

J U L Y 1 9 7 2

VOL. 69, NO. 7

---

237-7  
206th ANNUAL MEETING  
TRANSACTIONS ISSUE

# THE MEDICAL SOCIETY OF NEW JERSEY

## Endorsed Insurance Plans

### ACCIDENT AND HEALTH INSURANCE

**\$1,200** a month maximum BASIC total disability benefit.  
Accident: from 1st day, up to 5 years (Partial Accident  
Disability, half benefit up to six months)

**PLUS** Sickness: from 8th day, up to 2 years  
Accident: may be EXTENDED to Lifetime  
Sickness: may be EXTENDED to 7 years

**\$1,000** a month maximum NEW LONG-TERM PLAN.  
Payable up to Lifetime for accident — Age 65 for sickness  
Choice of waiting periods:  
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

### ★ ★ ★ LIFE INSURANCE

**\$10,000 to \$150,000** of Convertible Term Life Insurance  
(Guaranteed exchangeable at any time into Permanent Cash  
Value life insurance without medical examination)

**\$10,000 to \$50,000** of Convertible Term Life Insurance  
available for spouse, dependent children  
and employees.

### ★ ★ ★ MAJOR EXPENSE INSURANCE

**\$25,000** maximum for Covered Expenses as stated in the policy for each  
accident or sickness, covering member, spouse, and eligible  
children. \$750 deductible, 20% co-insurance. (Physicians' and  
surgeons' fees are not a Covered Expense.)

### ★ ★ ★ HOSPITAL-MONEY PLAN

**\$20-\$30-\$40** per day paid for each day that you or your depend-  
ents are hospitalized, from the first day for as long as  
365 days for any one accident or sickness. Benefits  
are tax-free.

### ★ ★ ★ SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

**\$200,000** maximum for member, covering accidental death, dismember-  
ment, loss of sight, total and permanent disability, exposure  
and disappearance. \$100,000 maximum for spouse (without  
disability benefit).

★ ★ ★

**II.R. 10 (KEOGH) RETIREMENT PLAN ★ ★ CORPORATE MASTER PLAN**

#### APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations for  
acceptance of risks. New members have special privileges during the first few  
months of membership; ask for specific details if you were recently elected or have  
applied for membership.

*Information and claim service are as close as your telephone.*

**E. & W. BLANKSTEEN AGENCY, INC.**

75 MONTGOMERY STREET, JERSEY CITY, NEW JERSEY 07302

(201) DElaware 3-4340

So much goes into making  
**LAKE NAOMI**  
the Poconos' incomparable  
leisure-home community



take for example our new  
**SWIMMING POOL COMPLEX**

The BIG private lake of the Pocono Mountains, Lake Naomi, each year moves further beyond comparison among the area's most inviting leisure-home communities by adding new recreational facilities and unique community advantages. Last year, it was a 75' x 165' heated Olympic-size swimming pool, complete with diving well, wading pool and poolside pavilion. This year we're putting finishing touches to two outstanding new facilities. One is a Tennis Club complex with eight tournament-caliber clay courts and its own clubhouse. Another is a full-featured Youth

Activities Center, focal point of a diversified recreational counseling program.

Rounding out Lake Naomi's many special attractions are the Naomi Clubhouse with cocktail lounge and dining room overlooking the Lake . . . six sand beaches with lifeguards . . . great golf, fishing, horseback riding and skiing practically at your doorstep . . . finest all-weather paved roads . . . property patrolled year 'round by Lake Naomi's Ranger . . . quality-built custom houses . . . financing arranged.

**COME SEE WHY SO MANY DOCTORS** build their leisure-time homes at Lake Naomi. Office and house models open daily on Rt. 940 at Pocono Pines. Reached via 80 & 81E or by N.E. Ext. of Pa. Turnpike. Phone 717-646-2222.





# FAIR OAKS HOSPITAL and ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

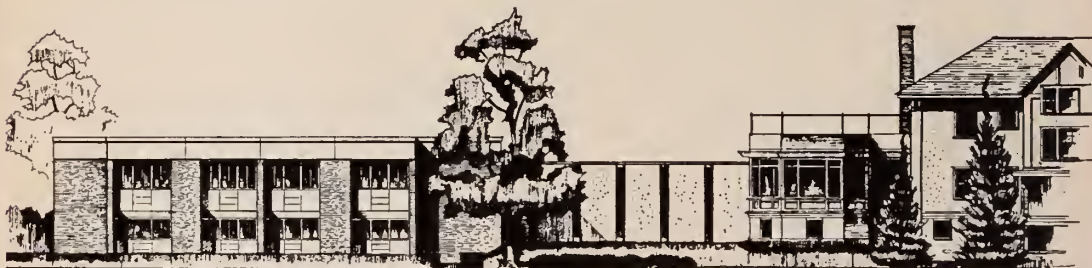
An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

Sergio D. Estrada, M.D., Medical Director  
Oscar Rozett, M.D., Medical Administrator  
Miss M. M. Kennedy, R.N., B.S., Director, Nursing Service

Granville L. Jones, M.D., Director of Research  
Felix A. Ucko, M.D., Director, Adolescent Program

Electro and Indoklon shock therapies. Insulin coma therapy. Pharmacotherapy. Individual and Group psychotherapy. Complete Occupational, Recreational, and Social Service Departments.

For descriptive literature write Thomas P. Prout, Jr., Administrator



*Serving Industry with Integrity*



SOUTH MOUNTAIN  
LABORATORIES • INC

*for CONTROL-RESEARCH*

#### SERVICES IN

- PHARMACOLOGY
- ENDOCRINOLOGY
- TOXICOLOGY
- COSMETICS
- BIO-ASSAY
- PLASTIC IMPLANT
- HUMAN SKIN TESTING
- BIOAVAILABILITY

487 Valley Street, Maplewood, N. J. 07040  
phone (201) 762-0045



# 6,500

# New Jersey Physicians have voted for Prevailing Fees...

## Have you?

Over 6,500 New Jersey physicians have joined the Blue Shield Prevailing Fee Program. Have you?

If not, this message is directed to you — especially if you are among the nearly 1,300 Participating Physicians in Blue Shield's Basic program who have not yet signed up for Prevailing Fee. Surely those who support the service benefits concept under a less than usual and customary fee schedule should welcome a service benefits program that pays usual and customary fees.

Many of those 1,300 Basic Participating Physicians may be wondering why some payments for their services are going to subscribers and not to them. The reason is that only Prevailing Fee Participating Doctors are paid direct for services to Prevailing Fee subscribers; Prevailing Fee is a separate program with a separate participation agreement.

Prevailing Fee — which should become the dominant Blue Shield program — does more for both the physician and subscriber. The Participating Doctor receives his usual and customary fees — direct from

the Plan — for covered services. The subscriber, regardless of his income, receives paid-in-full coverage for eligible services from a Participating Doctor.

For Prevailing Fee to reach its full potential the widest possible participation by physicians is essential. Subscriber groups must have widespread availability of paid-in-full coverage, through Participating Doctors, to justify the higher premium required for Prevailing Fee. The more physicians that participate, the more groups will purchase Prevailing Fee, and the more payments of usual and customary fees, rather than basic scheduled fees, will be made to Participating Doctors.

Ask a Physician Relations representative to call on you and explain Prevailing Fee in detail. You may be pleasantly surprised at how easy it is to start receiving payment of your usual and customary charges direct from Blue Shield for Prevailing Fee patients.

Just call collect (201) 456-3250. You'll be glad you did.



## BLUE SHIELD

Medical-Surgical Plan of New Jersey

# THE MEDICAL SOCIETY OF NEW JERSEY

*Founded July 23, 1766*

## Officers and Trustees

### PRESIDENT

William J. D'Elia, M.D. (Monmouth) ..... Neptune City

### PRESIDENT-ELECT

Matthew E. Boylan, M.D. (Hudson) ..... Jersey City

### FIRST VICE-PRESIDENT

James A. Rogers, M.D. (Passaic) ..... Paterson

### SECOND VICE-PRESIDENT

John J. McGuire, M.D. (Essex) ..... Newark

### IMMEDIATE PAST-PRESIDENT

E. Vernon Davis, M.D. (Burlington) ..... Mount Holly

### SECRETARY

Louis F. Albright, M.D. (Monmouth) ..... Spring Lake

### TREASURER

Samuel J. Lloyd, M.D. (Mercer) ..... Trenton

## Trustees

### CHAIRMAN

A Guy Campo, M.D. (1973) (Gloucester) ..... Westville

### SECRETARY

David Eckstein, M.D. (1975) (Mercer) ..... Trenton

Robert C. Anderson, M.D. (1975) (Essex) ..... Newark

Francis J. Benz, M.D. (1973) (Morris) ..... Chatham

George L. Benz, M.D. (1974) (Essex) ..... Newark

Edward J. Bourns, M.D. (1975) (Union) ..... Westfield

Harold L. Colburn, Jr., M.D. (1973) (Burlington) ..... Mount Holly

Charles L. Cuniff, M.D. (1975) (Hudson) ..... Jersey City

Richard E. Lang, M.D. (1975) (Passaic) ..... Passaic

Nicholas E. Marchione, M.D. (1974) (Cumberland) ..... Vineland

I. Edward Ornaf, M.D. (1975) (Camden) ..... Camden

Howard D. Slobodien, M.D. (1975) (Middlesex) ..... Perth Amboy

James S. Todd, M.D. (1974) (Bergen) ..... Ridgewood

## Councilors

### FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Thomas S. P. Fitch, M.D. ..... Plainfield (1975)

### SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

John L. Olpp, M.D. ..... Englewood (1974)

### THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. ..... Trenton (1973)

### FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. ..... Haddonfield (1975)

### FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

John S. Madara, M.D. ..... Salem (1974)

## AMA Delegates

Joseph P. Donnelly, M.D. (1973) ..... Jersey City

Frank J. Hughes, M.D. (1974) ..... Gloucester

John E. Kustrup, M.D. (1974) ..... Trenton

Luke A. Mulligan, M.D. (1974) ..... Leonia

Isaac N. Patterson, M.D. (1973) ..... Westville

Emanuel M. Satulsky, M.D. (1974) ..... Elizabeth



July 1972

## Publication Committee

Daniel B. Roth, M.D., *Chairman*

Arthur Krosnick, M.D.

John F. Marshall, M.D.

## Editor

Henry A. Davidson, M.D.

## Assistant Editor

Marjorie D. Treptow

## Advertising Manager

Joseph W. Cookson

## Executive Director

Richard I. Nevin

*The Journal* is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 815.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription (\$3.50) is included in the dues of Society members.

Subscription rates for nonmembers: \$7 per year (including postage), in advance. Outside USA, postage is additional.

Single copies are \$1.00 each.

Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

Second class postage paid at Trenton, New Jersey, and additional entry office.

Copyright 1972 by The Medical Society of New Jersey.

# Why send him to the islets of Langerhans?



Since sulfonylureas promote the release of insulin which is lipogenic and helps transport glucose into adipose tissue...

And since many overweight patients already have normal or high levels of endogenous insulin, why not consider DBI-TD?

It lowers blood sugar without stimulating

insulin secretion from the pancreas. And this may be important to the dieting diabetic.

In adult-onset, nonketotic diabetics uncontrolled by diet alone...

**DBI-TD<sup>®</sup> Geigy**  
**phenformin HCl**

lowers blood sugar without raising blood insulin.

**DBI<sup>®</sup> phenformin HCl**  
Tablets of 25 mg.  
**DBI-TD<sup>®</sup> phenformin HCl**  
Capsules of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoglycemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:*

This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic

determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin. **Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B)98-146-103-C

*For complete details, including dosage, please see full prescribing information.*

GEIGY Pharmaceuticals  
Division of  
CIBA-GEIGY Corporation  
Ardsley, New York 10502



# BECAUSE ALLERGIES ARE A YEAR-ROUND THING.

Let's face it, allergies don't go away. They're just around the corner. That's why it's important to keep your allergies under control year-round. A prescription-strength antihistamine, NOVAHISTINE LP, keeps your allergies under control all day long. It's the only prescription-strength antihistamine that's been clinically proven to keep your allergies under control all day long. And it's available in a new, convenient, easy-to-use form.

## NOVAHISTINE<sup>®</sup> LP

Prescription



DOW PHARMACEUTICALS

One Dow Center, Midland, TX 79701  
1-800-368-2746

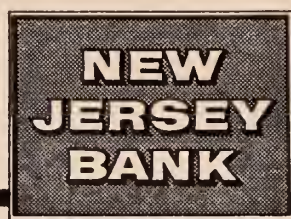




# PUT YOUR TRUST IN NJB

Available to physicians and their attorneys at NJB is a complete range of estate and personal trust services, including investment guidance and custody of securities. Our highly-trained specialists have the knowledge and know-how required to effect long-range plans, and the experience necessary for the prudent and profitable management of other people's property. ■ Should you be interested in any of our Trust or Investment Department services, we'd be most happy to discuss them with you.

TRUST OFFICES: 129 Market Street, Paterson  
657 Main Avenue, Passaic



"LEAD BANK OF GREATER JERSEY BANCORP"

**"Prescribe With Confidence"**

**K A T E S   B R O S .**

**SCIENTIFIC SHOE FITTING**

**A Shoe and Last for Every Foot**

*Barefoot... Freedom*

**SOLD ON Rx ONLY**

**CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN  
OUTFLAIR SHOES FOR CLUB FEET**

**400 MAIN STREET**

**HACKENSACK, N. J.**

**201-487-1779**

**Dennis Brown Splints — In all sizes — Carried in stock  
CUSTOM SHOE SHOP ON PREMISES**



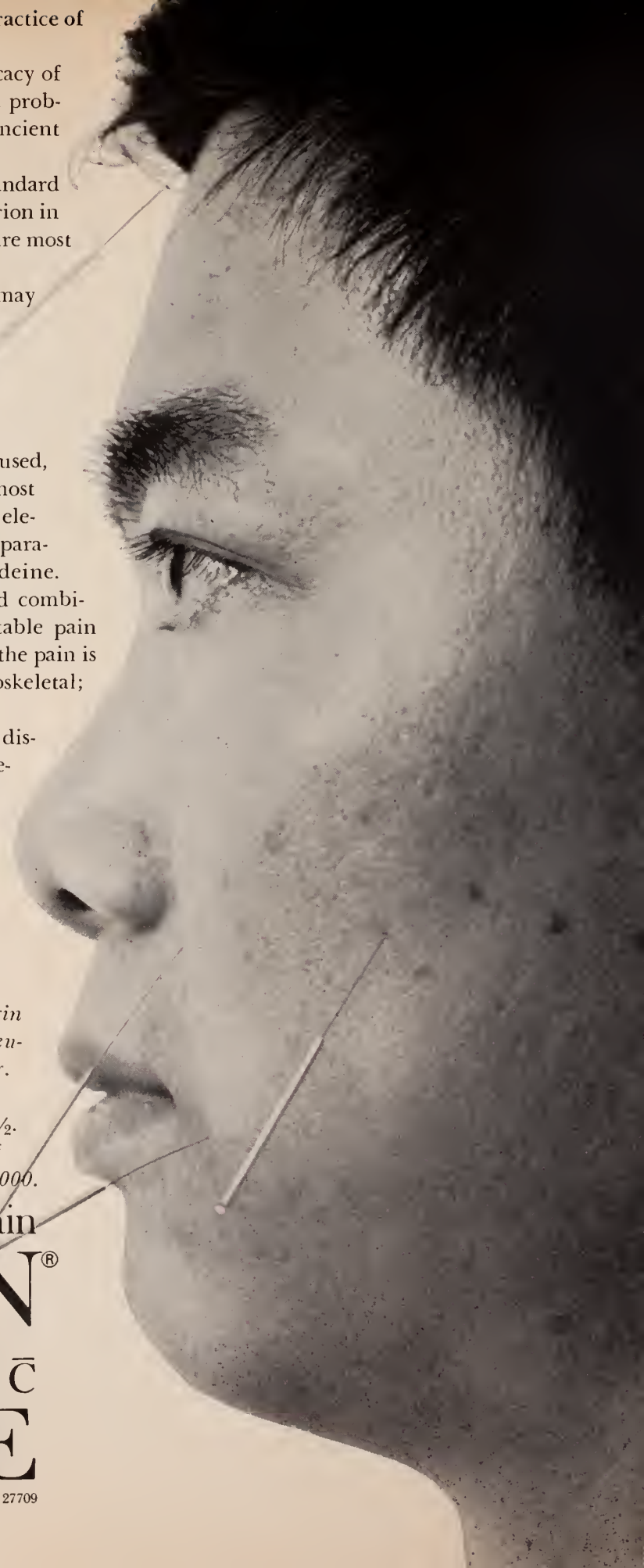

Prompt relief of pain is a lot of what the practice of medicine is all about...East or West.

In much of the Far East, the analgesic efficacy of Empirin® Compound with Codeine would probably be measured against acupuncture, an ancient and traditional therapeutic system.

In America, codeine sets such a high standard for oral analgesia, that it has become a criterion in terms of which other major oral analgesics are most often measured.

Synthetic and other oral analgesics may offer some of the properties of codeine, but not one can provide both its benefits and potency. And codeine provides an antitussive bonus.

Empirin Compound with Codeine is the most widely used, and probably the most pharmaceutically elegant analgesic preparation providing codeine. It's the time-tested combination for predictable pain relief... whether the pain is visceral or musculoskeletal; acute or chronic.

  
  
  
  
New prescription flexibility. At your discretion, and where state law permits, a prescription for Empirin Compound with Codeine may now be refilled up to five times in six months.

*Empirin Compound with Codeine No. 3 contains codeine phosphate\* (32.4 mg.) gr. 1/2. No. 4 contains codeine phosphate\* (64.8 mg.) gr. 1. \*(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3 1/2, phenacetin gr. 2 1/2, caffeine gr. 1/2. Bottles of 100 and 1000.*

But for relief of Western pain

# EMPIRIN® COMPOUND $\bar{c}$ CODEINE

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709

## KESSLER INSTITUTE FOR REHABILITATION

West Orange, New Jersey

- A voluntary, non-profit, non-sectarian specialty hospital and rehabilitation center for physically handicapped children and adults providing intensive and comprehensive medical, social, psychological, and vocational services for patients with any physical impairment due to a congenital condition, accident or disease.
- In-patient and out-patient service facilities include a 48-bed, air-conditioned in-patient wing, swimming pool, and modern treatment facilities.
- Fully accredited by the Joint Commission of Accreditation of Hospitals. and the Commission on Accreditation of Rehabilitation Facilities.
- Provider of Services under Medicare and Medicaid.

ADMISSION BY MEDICAL REFERRAL TO  
DIRECTOR OF ADMISSIONS

RICHARD A. SULLIVAN, M.D.,  
Medical Director

HENRY H. KESSLER, M.D.,  
Director of Professional  
Education and Research

WILLIAM K. PAGE, Executive Director  
Telephone: 731-3600



*"My secret?  
For heartburn I always  
use 'Dicarbosil'."*



**Dicarbosil®**  
ANTACID

Write for Clinical Samples  
**ARCH LABORATORIES**  
319 South Fourth Street, St. Louis, Missouri 63102

ALSO AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

## Android® 5

MUQUETS  
BUCCAL Tabs

Methyltestosterone N.F. - 5 mg.

## Android® 10

Methyltestosterone N.F. - 10 mg.

## Android® 25

Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosterone-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpubertal cryptorchidism	30 mg.

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

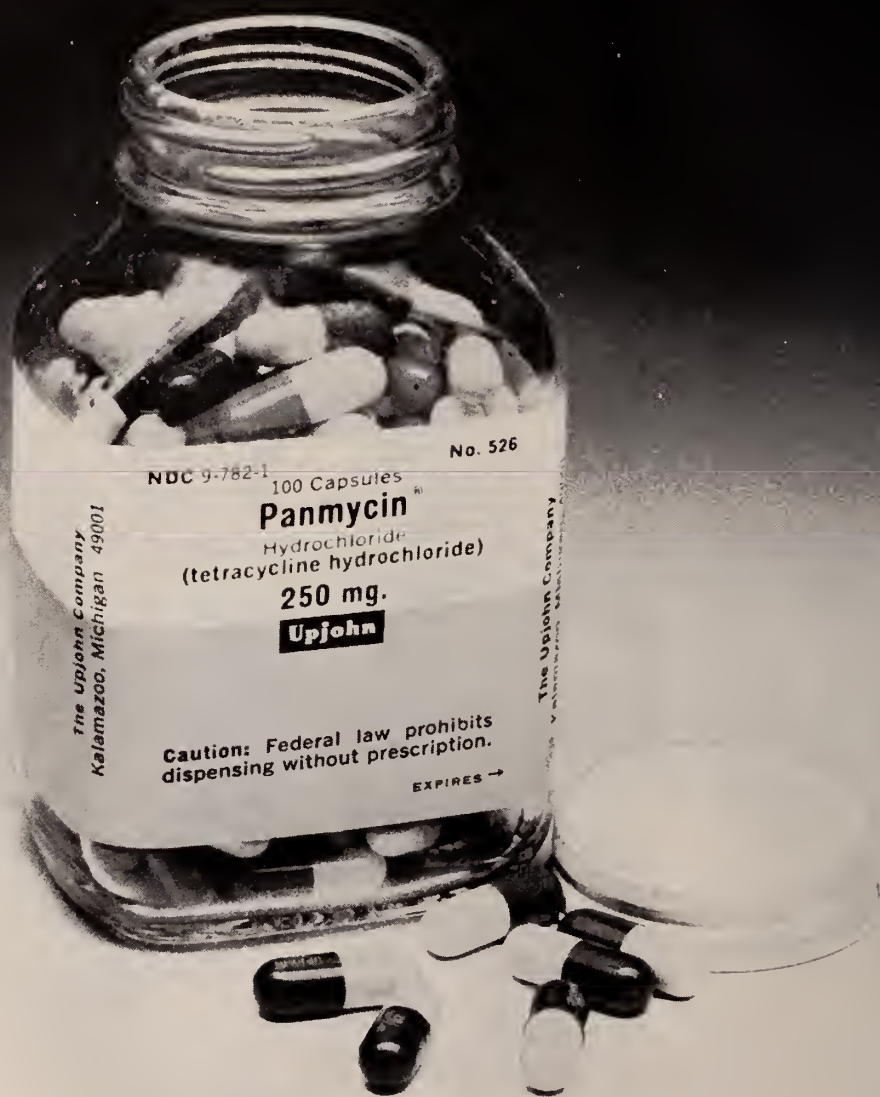
Write for Literature and Samples

**BROWN**

THE BROWN PHARMACEUTICAL CO., INC.  
2500 West 6th Street, Los Angeles, California 90057



# Upjohn's low-priced tetracycline



## Panmycin<sup>®</sup>


(tetracycline HCl, Upjohn)  
Available as 250 mg capsules and  
tetracycline syrup 125 mg/5 ml

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2142-6





In the glaucoma patient  
on cerebral or peripheral  
vasodilator therapy  
no treatment  
conflict  
reported

# VASODILAN<sup>®</sup>

(ISOXSUPRINE HCl)  
the compatible vasodilator

- no reported increase of intraocular pressure
- conflicts have not been reported with miotics, corticosteroids, antihypertensives, hypoglycemics or diuretics

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

*Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators<sup>1-4</sup> have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement<sup>2,4</sup> and observations of clinical improvement.<sup>1,3</sup>*

**Composition:** VASODILAN tablets, isoxsuprine HCl, 10 mg. and 20 mg. **Indications:** In cerebral vascular disorders for relief of symptoms due to vascular insufficiency associated with various conditions such as arteriosclerosis and hypertension. In peripheral vascular disorders for relief of symptoms such as intermittent claudication, coldness, numbness, pain and cramping of the extremities—in the management of arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebotic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Dosage and Administration:** In peripheral and cerebral vascular disorders—10 to 20 mg. three or four times daily. **Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. **Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose. **Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose. **References:** (1) Clarkson, I. S., and LePere, J. M.: *Angiology* 11:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: *Angiology* 15:70-74 (Feb.) 1964. (3) Dhrymiotis, A. D., and Whittier, J. R.: *Curr. Ther. Res.* 4:124-128 (April) 1962. (4) Whittier, J. R.: *Angiology* 15:82-87 (Feb.) 1964.

# When you prescribed Orinase<sup>®</sup> (tolbutamide, Upjohn) 14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

**Contraindications:** Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

**Pregnancy Warning:** The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated fetocidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

**Precautions:** Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions; develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physi-



# Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know that if these measures fail the addition

of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

## Orinase® 0.5 g. tablets (tolbutamide, Upjohn)

cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

**Adverse Reactions:** Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenylhydrazide may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without pro-

ducing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

**Supplied:** 0.5 g. Tablets—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

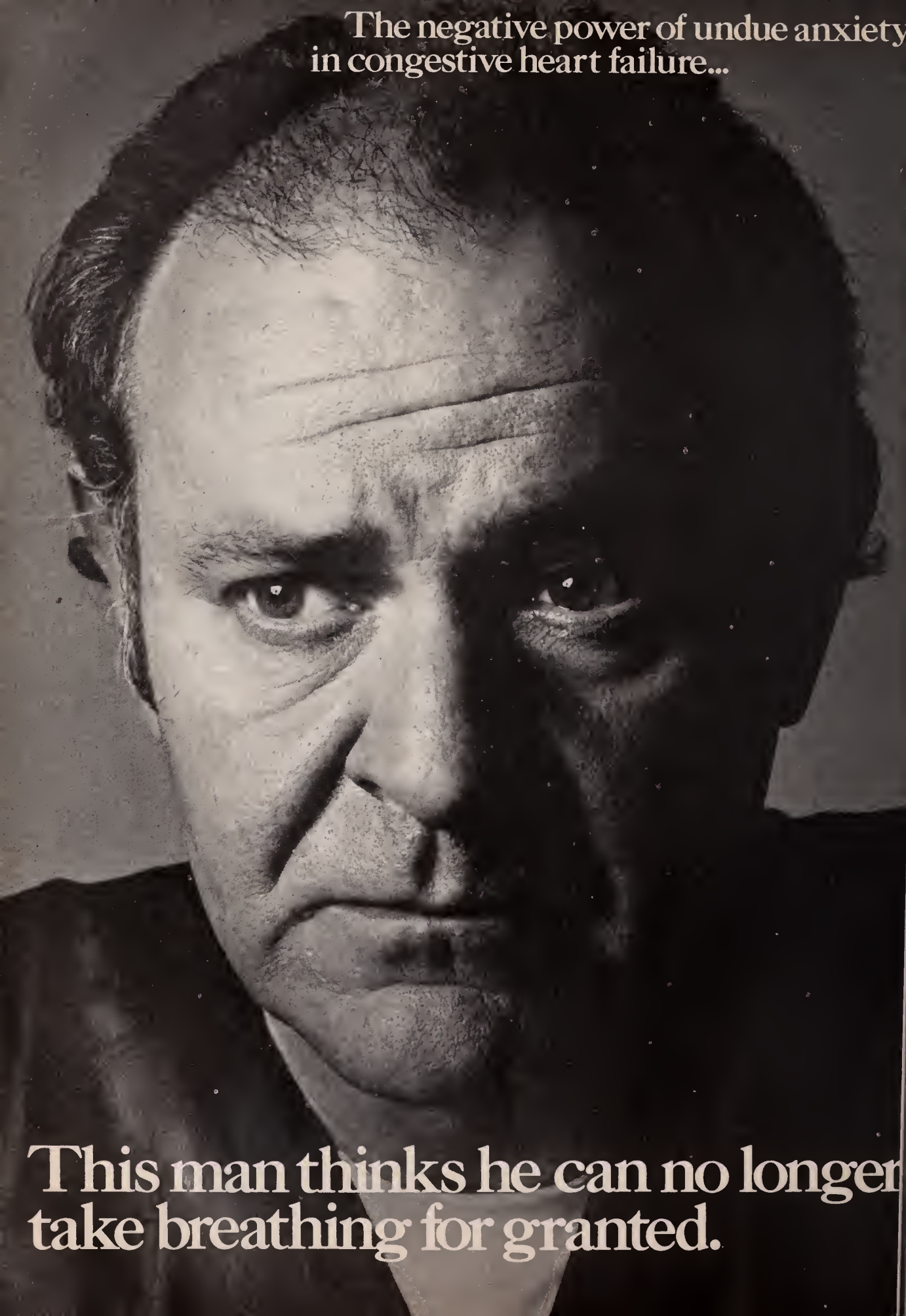
**For additional product information, see your Upjohn representative or consult the package insert.**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1971 The Upjohn Company JA71-1495 MED B-5-S LAO-6

**Upjohn**

The negative power of undue anxiety  
in congestive heart failure...



This man thinks he can no longer  
take breathing for granted.



Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

#### *Aid in rehabilitation*

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

#### *Concomitant use with primary agents*

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supply:** Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

The positive power of

**Libritabs®**  
(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

**t.i.d./q.i.d.**

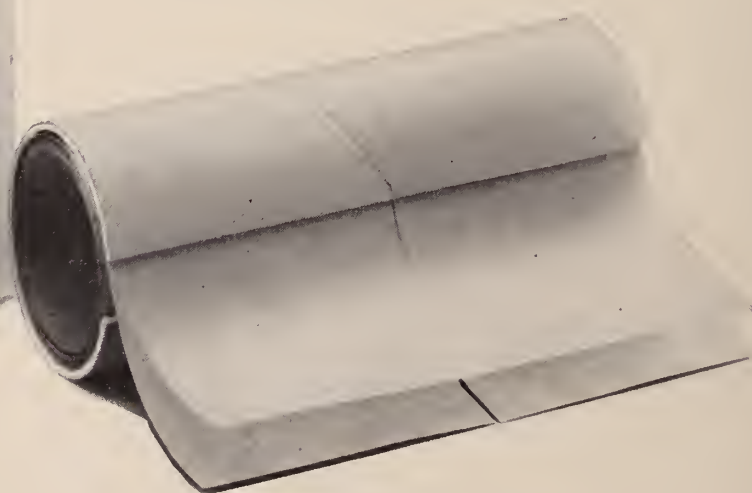
up to 100 mg daily

for severe anxiety  
accompanying  
congestive heart failure



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# One of the familiar line of Cordran<sup>®</sup> flurandrenolide products



*Additional information  
available to the  
profession on request.*

200469



Eli Lilly and Company  
Indianapolis, Indiana 46206

---

# EDITORIALS

---

## Who Needs the AMA?

The occasional cry is raised, who needs the AMA? What does it do for me? It's too liberal! It's too reactionary! It's too conservative!

Anyone who has followed the AMA knows that the voices of dissension and criticism are now being heard in that organization. As all organizations must change to survive, the AMA is changing. What direction it takes depends on those of you who are interested enough to have a part of the action.

There is not a single physician in this country today who has not benefited from the AMA when one considers the fantastic amount of work that they have done on a national scale in all facets of medicine and public health. A look at their journals, magazines, committees, councils, and task forces will vouch for this.

It is morally unacceptable for us to share in the benefits of the AMA without supporting the AMA.

## Research Starts with Clinicians

Modern scientific methods are indeed magnificent. The white-coated investigators do their research, the chrome-plated equipment shines, fluids bubble in their retorts, and computers' lights flash gaily. But the accuracy of it all depends on the validity of the basic bedside investigation. Poor observation at the first doctor-patient contact point will produce errors that no amount of scientific processing can ever correct.

And to improve this kind of observation, no special machinery is needed. We need here sophisticated physicians rather than sophisti-

cated equipment. The doctor in the front line needs four skills: he must know how to ask about and react to complaints; he must know how to solicit a history—which again means knowing what questions to ask; he must know how to do a meticulous physical examination; and he must know how to register, record, and to retrieve his findings. And he needs a fifth sense too—a kind of human compassion which tells the patient that he is interested, so that, warmed by this kind of rapport, the patient's story will be more meaningful, as well as more productive. Here then is the beginning of all medical research; the prime data for the "programming." This too is science as well as art. Perhaps our increasing concern with the laboratory has dulled the edge of our diagnostic clinical acumen. Or, the glamor of equipment has downgraded the traditional bedside skills. There should be comfort in the fact that the one doctor who won't be replaced by a push button is the clinician who has to assemble the data to feed into the machine.

## Thrust, Dialogue, and Nitty-Gritty

There are, it seems, fashions in words as in clothes. When once we spoke of dichotomies and parameters, today we talk of dialogue and thrust. The physician is, perhaps, less enamored of jargon than the social worker or psychologist. Analysts sometimes talk Libidinese instead of English, but even this convention is now becoming unconventional. Sometimes our communication with a layman breaks down, not because we use words that he doesn't understand, but rather because we use words that he does understand—but not in our sense. One thinks here of such words as ego, catharsis, trauma, affect, and anal. They are in anybody's dictionary, but not quite in our meaning. Then there are words that are idiomatic to one's specialty: libidinal, for instance, or cathexis. And finally, there is plain jargon, which brings us back to thrust and dialogue.



The difficulty is that a good word or phrase, shiny and newly minted, soon becomes tarnished with overuse. The first pharmacologist to think of a broad spectrum antibiotic had a colorful phrase. But by now, "broad spectrum" has become as obsolete as "the \$64 question" and is used by lazy writers and speakers who can't think of the simple word "versatile." This is what happened to words like "confrontation" and "dialogue," once vivid expressions which packed a lot of meaning into a single word. Verbal artistry consists in developing the common English word which expresses the meaning, rather than the highly technical one. Take "affect" for instance. Even fairly sophisticated people in the human behavior field don't know what it means. If we say "mood" we come close enough for all practical purposes, though if you have a compulsion to split hairs, you can see a subtle distinction between "affect" and "mood." And an unresolved Oedipus Complex can be explained in less esoteric language. So maybe we ought to get down to a basic English, the "nitty-gritty," so to speak.

## Medical Leadership in Geriatrics

Only a minute proportion of us have any real interest in geriatrics. No one has figured out just why we have this type of disinterest. Perhaps it is because we feel we can't do much for the patient. Perhaps because it seems like a more efficient use of our time to divert it to people who have long lives ahead of them. Maybe it is because we ourselves are getting older, and don't like to be reminded of that. Or could it be that we are caught in a youth-oriented society and older people are easily put in the discard pile? Another possibility is that old people remind us of our own parents toward whom we have some guilt feelings. Or are doctors so achievement-oriented that when we can't achieve much, we lose interest? If you are treating an old person, you're likely to be a loser in that game before long and no one likes to back losers.

Some of the problem is financial. Few of the aged can afford regular fees for long. Medicare does not meet the need to the extent that was promised. The premium for part B coverage has gone up so that about 15 per cent of Medicare patients can't afford that coverage. (Figures from page 45 of the April 7, 1972, *Medical World News*.) Even the part A deductible has gone up to almost \$70 which many beneficiaries just can't afford. This, incidentally, is a good example of the problem of medical leadership in geriatrics. We, as a profession, were opposed to Medicare, seeing, correctly, that it would lead to bureaucratic red tape, rising costs, and the possibility of fraud and chicanery. But to too many of the public, our opposition to Medicare seemed to be simply a reactionary reflex. We didn't display any sparkling leadership in this problem.

Nursing homes represent another area calling for professional leadership. Many investigators have found conditions in nursing homes to be poor, and we as a profession haven't taken the leadership in correcting these. We have been too glib in applying the "chronic brain syndrome" label to many old people, consigning them, in effect, to the ranks of the incurable and unhelpable. We should have taken some responsibility in finding ways of keeping old folks in the community but haven't really taken much initiative here. It is true that this is a responsibility which we share with social agencies, private citizen groups, and government. But we are quick to resent it if one of these tries to assume leadership here, and we have a moral duty to assume some initiative in the nursing home field.

The old person has traveled a long road and has many interesting things to tell us about his journey. Listening to a senior citizen can be fun if we don't dismiss it hastily or seem to find it a source of amusement. In the days before we had miracle drugs and bold surgery, we often found our ministry in listening with attentive interest to what the patient had to say, since there wasn't much we could provide except an attentive ear. To be true to our leadership, we need some of that quality again.



# NEW FOR ULCER... LIQUID **MYLANTA-II**<sup>®</sup>

## GREATER NEUTRALIZING IMPACT

- ☐ more neutralizing action per  
teaspoonful than standard antacids
- ☐ without the acid rebound  
associated with calcium carbonate
- ☐ pleasant tasting / rapidly effective
- ☐ non-constipating / non-laxating

**MYLANTA-II**<sup>®</sup> LIQUID

aluminum and magnesium hydroxides plus simethicone

**NEW HIGH POTENCY ANTACID  
FOR RELIEF OF ULCER PAIN**



STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

# Femininity & Vaginitis





Many women still believe that a douche is a cure-all for vaginal secretions and malodor. Mother tells daughter and the myth is perpetuated.

Other cosmetic products are not much better. Though they may be effective in some minor infections, they cannot touch the real medical problem, which very often is trichomonal vaginitis.

Medicine's most effective cure for trichomonal vaginitis is Flagyl® (metronidazole). It is also pleasantly

feminine because it provides the simplicity of oral medication . . . frees women from the unpleasant mess and bother of douches.

When the problem is trichomonal vaginitis . . . remember Flagyl. It cures trichomoniasis with an unmatched high degree of effectiveness.

Flagyl is indicated for the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.



# Flagyl®

(brand of  
metronidazole)



**Indications:** For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. The oral form is indicated also for intestinal amebiasis and amebic liver abscess.

**Contraindications:** Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

**Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

**Precautions:** Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

**Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, consti-

pation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in EKG tracings.

#### Dosage and Administration

**For Trichomoniasis. In the Female:** One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used, one 500-mg. insert is*

placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. **In the Male:** Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

**For Amebiasis. Adults:** For acute intestinal amebiasis, 750 mg. orally three times daily for 5 to 10 days. For amebic liver abscess, 500 to 750 mg. orally three times daily for 5 to 10 days.

**Children:** 35 to 50 mg./kg. of body weight/24 hours, divided into three doses, orally for ten days.

**Dosage forms:** Oral tablets 250 mg.  
Vaginal inserts 500 mg.

## Flagyl® (metronidazole)

SEARLE Manufactured by SEARLE & CO.  
San Juan, Puerto Rico 00936

Address medical inquiries to:  
G. D. Searle & Co., Medical Department  
P. O. Box 5110, Chicago, Illinois 60680

Research in the Service of Medicine

# DYAZIDE®

Each capsule contains 50 mg. of Dyrenium®  
(brand of triamterene) and 25 mg. of hydrochlorothiazide.

Trademark

## CAN STOP POTASSIUM DEPLETION BEFORE IT STARTS WITH NO SACRIFICE OF THIAZIDE EFFECTIVENESS

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

**\*Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $>5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis,

and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

**Supplied:** Bottles of 100 capsules.

**SK&F CO.**

Carolina, P.R. 00630

a subsidiary of Smith Kline & French Laboratories

## IN EDEMA\*—IN HYPERTENSION\*



# TRANSACTIONS

1972 House of Delegates

206th ANNUAL MEETING

The Medical Society of New Jersey

May 6-9, 1972



President, E. Vernon Davis, addressing House of Delegates.



(Right) Dr. Davis accepting Fellow's Pin from Immediate Past-President, Emanuel M. Satulsky.



(Left) Burlington County Medical Society (Arthur C. Dietrick, President) presenting Dr. Davis with commemorative gift.

# INDEX

Amendments offered in Reference Committee reports are noted in *italics*; actions taken by the House of Delegates are indicated by small boldface type.

	Reference Committee	Page
Abortion Laws, Liberalization of—Resolution #2	"A"	Tr 106
Accreditation of Hospitals (1971 Resolution #13)	"F"	Tr 23
Affiliate Membership	Const. & Bylaws	Tr 53
Membership or Adjunct Membership	Const. & Bylaws	Tr 28
Alcoholism	"F"	Tr 72
Control Bill, S-893—Resolution #30	"E"	Tr 124
Detection and Prevention Clinics—Resolution #16	"F"	Tr 115
AMA Council on Medical Education, Opposition to Regulations Concerning		
Residency Training—Resolution #13	"D"	Tr 114
Delegates	"A"	Tr 15
Delegates, Election of—Resolution #1	"A"	Tr 106
Membership, Survey of Methods to Increase—Resolution #6	"A"	Tr 110
System of Coding and Nomenclature (1971 Resolution #27)	"C"	Tr 17
Amphetamines and Similar Drugs, Limitation on—Resolution #19	"F"	Tr 118
Annual Meeting	"H"	Tr 32
Appeal Hearings, Guidelines for	"A"	Tr 30
Assessment	"B"	Tr 38
Automated Bookkeeping System	"B"	Tr 17
Billing Procedures, Ethical Acceptability of	"A"	Tr 28
Blood Banking Procedures, Uniformity of	"C"	Tr 27
Procurement, Crash Program on	"E"	Tr 18
Transfusion is a Service Not a Sale (1971 Resolution #10)	"E"	Tr 20
Blue Cross Group Enrollment—Resolution #27	"C"	Tr 122
Shield, Practice of Medicine by—Resolution #25	"C"	Tr 121
Cancer Control	"C"	Tr 77
Certificate of Need (1971 Resolution #36)	"F"	Tr 69
Child Health	"G"	Tr 78
Chiropractors, Use of Physical Therapy by	"E"	Tr 21
College of Medicine and Dentistry of New Jersey		Tr 100
Component Societies, Conference with Presidents	"A"	Tr 15
Conflict of Interest, Avoidance of—Resolution #7	"C"	Tr 111
Conservation of Vision, Hearing, and Speech	"G"	Tr 79
Constitution and Bylaws, Revision of	Const. & Bylaws	Tr 52
Continuing Medical Education—Resolution #11	"D"	Tr 113
Medical Education, Accreditation of	"D"	Tr 46
Medical Education, Physician Participation	"D"	Tr 47
Medical Education, Requirement for MSNJ Membership—Resolution #10	"D"	Tr 112
Credentials	"A"	Tr 36
Drug Abuse	"F"	Tr 73
Abuse Registry—Resolution #17	"F"	Tr 116
Education, Accreditation of—Resolutions #14 and #15	"E"	Tr 114, Tr 115
Election		Tr 144
Emergency Medical Care	"D"	Tr 83
Emeritus Membership, Nomination for; and Supplemental	"H"	Tr 102, Tr 103
Emotional Disorders of Childhood and Adolescence	"F"	Tr 74
Environmental Health	"C"	Tr 79
Health—Resolution #22	"C"	Tr 119
Executive Director	"A"	Tr 31
Eye Examinations, for Prescriptions of Corrective Lenses, Limitation of		
Right to Administer—Resolution #32	"G"	Tr 125
Examination, Minimum (1971 Resolutions #34 and #37)	"G"	Tr 26
Medication Ruling (1971 Resolution #12)	"E"	Tr 21
Family Physicians (1971 Resolution #14)	"D"	Tr 45
FDA Policy on Combination Drugs (1971 Resolution #32)	"C"	Tr 25
Finance and Budget	"B"	Tr 37
Fiscal Intermediaries, Criteria Used by	"F"	Tr 23
Intermediaries, Liaison Committee with (1971 Resolution #39)	"F"	Tr 23
Fitness to Drive—Resolution #23	"G"	Tr 120
Foundation Approach to Medical Care	"F"	Tr 22
Headquarters, Expansion of	"B"	Tr 16
Health Care Facilities Planning Act, Financing of (S-841)—Resolution #31	"E"	Tr 125
Planning Agencies	"F"	Tr 23
Hepatitis, Transfusion-Associated	"G"	Tr 27
HMO Concept (1971 Resolution #43)	"F"	Tr 25
Honorary Membership	"H"	Tr 36
Hypnosis for Medical Purposes, Regulation of—Resolution #24	"E"	Tr 120

	Reference Committee	Page
Information to Component Societies, Prompt Transmittal of—Resolution #5	"A"	Tr 110
Interns and Residents, Power to Sign Certain Legal Documents	"E"	Tr 18
Internships and Residencies in New Jersey Hospitals (1971 Resolution #44)	"D"	Tr 19
Judicial Council	"A"	Tr 28
Kaufman, Jerome George, M.D., Memorial Resolution		Tr 105
Legislation and Supplemental	"E"	Tr 55, Tr 63
Licensure by Endorsement for Diplomates of Specialty Boards—Resolution #12	"D"	Tr 113
Limit Debate, Action to		Tr 52
Maternal and Infant Welfare	"G"	Tr 80
McCall, Jesse, M.D., Memorial Resolution		Tr 105
M.D. Curriculum (1971 Resolution #19)	"D"	Tr 45
MECO Projects, SAMA's	"D"	Tr 20
Medicaid, Improper Denial of Physicians' Claims Under—Resolution #18	"F"	Tr 117
Medical Assistants (1971 Resolution #9)	"F"	Tr 68
Defense and Insurance	"C"	Tr 40
Education and Supplemental	"D"	Tr 45, Tr 46
Practice Act, Amendment to—Resolution #20	"E"	Tr 118
Services	"F"	Tr 68
Student Loan	"B"	Tr 48
—Surgical Plan	"C"	Tr 89
Medicine and Religion	"D"	Tr 85
Membership of Interns and Residents—Resolution #3	"A"	Tr 108
Mental Health	"F"	Tr 71
Retardation	"F"	Tr 74
MSP Board Nominations, Discontinuance of Clearing through MSNJ—		
Resolution #8	"C"	Tr 111
—HSP Coverage for Children of Subscriber Physicians (1971 Resolution #31)	"C"	Tr 18
Board of Trustees Nominations	"C"	Tr 19
Neurological and Related Disorders	"F"	Tr 75
"No Fault" Professional Liability Insurance—Resolution #9	"C"	Tr 112
Nominating Committee, Report of		Tr 144
Procedures—Resolution #4	"A"	Tr 109
Occupational Health, Workmen's Compensation, and Rehabilitation	"F"	Tr 70
Peer Review	"F"	Tr 24, Tr 69
Physician Assistants (1971 Resolution #18)	"F"	Tr 68
Physicians' Assistants, Position Statement on	"F"	Tr 68
Associates, Baccalaureate Program for (1971 Resolution #33)	"F"	Tr 23
Relief Fund	"B"	Tr 86
President	"A"	Tr 5
Project Hope/Vietnam	"B"	Tr 86
Professional Liability	"C"	Tr 42
Liability (1971 Resolution #24)	"E"	Tr 21
Public Health	"G"	Tr 76
Relations	"E"	Tr 81
Publication	"B"	Tr 51
Reference Committees:		
"A"		Tr 127
"B"		Tr 130
"C"		Tr 131
"D"		Tr 133
"E"		Tr 135
"F"		Tr 137
"G"		Tr 139
"H"		Tr 141
Constitution and Bylaws		Tr 142
Refresher Courses for Physicians, Compulsory—Resolution #28	"D"	Tr 123
Regional Medical Program—P.L. 89-239 (1971 Resolution #20)	"F"	Tr 69
Resolutions, Committee on	"H"	Tr 27
Retirement Plan for Physicians	"C"	Tr 87
Scientific Exhibits	"H"	Tr 34
Program	"H"	Tr 35
Secretary	"A"	Tr 6
Senate Bill 841, Disapproval of—Resolution #31	"E"	Tr 125
Bill 893, Support of—Resolution #30	"E"	Tr 124
Sewage Disposal from World Trade Buildings—Resolution #29	"G"	Tr 123
Smallpox Vaccination	"C"	Tr 26
Survey, Membership Opinion—Resolution #26	"A"	Tr 121
Transactions, 1971 House of Delegates		Tr 8
Treasurer	"B"	Tr 8
Trustees, Board of	"A"	Tr 15
Uterine Cancer, Endorsement of Goals of Task Force to Conquer—		
Resolution #21	"G"	Tr 119
Vice-Speaker	Const. & Bylaws	Tr 52
Woman's Auxiliary Advisory	"H"	Tr 54



---

# ANNUAL REPORTS

---

## President

E. Vernon Davis, M.D., Mount Holly

(Reference Committee "A")

I described my inauguration day as the "climactic day of my life." Now I am prepared to testify that the year of my Presidency of The Medical Society of New Jersey—incredibly swift in its passage and absorbing in its demands and interests—has been the climactic year of my life. It has been made evident to me that the profession of medicine today is involved in a universe of complex relationships, embracing everything from the most recent discoveries and developments in the art and science of medicine to the social, economic, and political problems and movements of our times. Day by day we are called upon for adjustments. We must weigh our decisions impartially and painstakingly, because the future not only of the profession but of the health and spirit of the nation and of our people is at stake.

That is why it was encouraging to me to have the inspiration and cooperation of the many members who serve our Society at so many levels and in so many capacities. To my fellow Officers, the Board of Trustees, the members of all of MSNJ's councils and committees, and to our gifted and dedicated staff I offer warm commendation and profound appreciation. In like fashion, I commend and thank the officers and members of all the component societies for their diligence and for their devotion to the ideals of the Society, the goals that together we pursue, and the welfare of the people whom we serve.

In the detailed reports separately submitted to the House are presented in summary the activities of the Society in the year that is now ending. In this report I should like to cite only a few selected items of action and accom-

plishment that I think are of significant value and promise to us all.

Legislative activities have been more intense than ever before, and I think you will agree with me that the Society's record concerning State legislation has been very gratifying. The Council on Legislation deserves our thanks for its work.

For the first time in many years, we are not being asked for an increase in premiums for our professional liability coverage. This, it seems to me, demonstrates the soundness of the thinking of the Committee on Medical Defense and Insurance which led to our recent change of carriers.

As a Society we have attacked the problem of transfusion-associated hepatitis and we are working with all other agencies involved in the effort to insure the collection and maintenance of an adequate supply of wholesome blood and blood derivatives, especially from voluntary donors, for the seriously ill of New Jersey.

We are strongly supporting S-789 to establish that blood is a service, not a sale.

We supported the recommendation of the New Jersey State Department of Health that compulsory smallpox vaccination on a routine basis be discontinued.

We are moving rapidly, under the stimulating leadership of the Standing Committee on Medical Education, to the adoption of criteria and procedures for evaluating and accrediting intrastate programs of continuing medical education.

We have endorsed the SAMA-MECO Project, which would place pre-clinical medical students in communities of New Jersey for summer education experience, and we have referred it for direction and implementation to the Committee on Medical Education.

We helped to prevail upon the State Board of Medical Examiners not to grant the use of physical therapy measures and modalities to licensed chiropractors.

We have established a State Peer Review Committee to guide peer review activities on a uniform basis wherever they occur.

We have likewise established a committee to study the foundation approach to medical care.

As a means of placing more New Jersey physicians on councils and committees appointed by the AMA Board of Trustees, we have established an ad hoc selection committee to produce recommendations for the consideration of the Board of Trustees.

In the course of the year I have learned much from visits to meetings of our component societies and of neighboring state medical societies. Everywhere the problems being dealt with are much the same, and the spirit of all concerned is vital and vigorous. The ever-increasing demand on the part of the public for both curative and preventive medical care of a high quality and the emphasis placed by

government and other third party payers on mechanisms to contain the costs for the delivery of that care without impairing the quality thereof confront physicians everywhere, as the deliverers of quality medical care, with challenges that must be met. It is imperative that we address ourselves to those challenges with a unity of purpose and of action. At no time in the history of American Medicine has it been more important that we of the profession work as one to preserve the freedom of judgment and of action that is indispensable for the rendition of optimum services to our patients. That is why the wholesome dedication and the uncompromising devotion of our members to their professional ideals and duties is encouraging to see. That is why the healthy growth of our membership is especially heartening. That is why we must do all that we can to encourage continuing and increasing membership in the American Medical Association. If it is true that a house divided against itself must fall, we must all strive mightily to safeguard the structure of the house of American Medicine. That, it seems to me, is for us the supreme challenge of our time.

For the honor and many satisfactions that my year has brought me, I am deeply grateful. I hope that my colleagues of the Society, in whose interests I have labored, will be pleased with the record of the year.

Approved (page Tr 127)

## Secretary

Louis F. Albright, M.D., Spring Lake  
(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the annual meeting of the American Medical Association in Atlantic City and the Clinical Meeting in New Orleans, Louisiana—serving in a dual role as MSNJ Secretary and an AMA Alternate Delegate. At state level, the

Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP			
(As of 31 December 1971)			
Active:	Paid .....	6,839	
	Exempt .....	499	7,338*
<hr/>			
Associate:	Paid .....	560	
	Exempt .....	53	613*
<hr/>			
State Emeritus .....		263	
Total of Above .....		8,214	
<hr/>			
State Honorary .....		8	
New and Reinstated Members:			
	Active .....	154	
	Associate .....	371	525
<hr/>			
Transfers within the state .....		23	
Transfers out-of-state and resigna-			
	tions .....	64	
Members deceased .....		126	
Members dropped:			
	Active (non-payment of dues) .....	30	
	Associate (non-payment of		
	dues) .....	10	40
<hr/>			

\*Adjusted for transfers out-of-state, resignations, and deaths.

#### AMA MEMBERSHIP

A total of 5,876 members of The Medical Society of New Jersey maintain active membership in the AMA (a decrease of 248 members from last year—an entitlement to one delegate). Based on active membership MSNJ is entitled to six delegates—one for each thousand members, or fraction thereof.

#### MEMBERSHIP DIRECTORY

Work is being carried forward to achieve the publication of the next edition of the *Membership Directory* in the fall of 1972, when, it is expected, distribution will be made to the entire membership.

The new *Directory* will embody the same features as that of the 1970-71 edition. These

include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (\*) to designate "Armed Forces", a single dagger (†) to designate associate, and a double dagger (‡) to designate emeritus membership; (3) the zip code will appear as the last item in each individual listing; (4) the hospital section of the *Directory* will again include the listings of hospital staffs; (5) the special membership supplement section—which now includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners in New Jersey, Guides for Physicians—Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Verification data sheets supplied to the membership will form the basis for the biographical data to be published in the 1972-73 edition, as did similar data sheets which were supplied to publish the 1970-71 *Directory*. With the cooperation of the membership, it is the hope of your Special Committee on Membership Directory to make this forthcoming *Directory* the most complete and accurate-edition yet published.

Approved (page Tr 127)



Louis F. Albright, Secretary.



## Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1972 interim financial report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Balance Sheet is presented as of 31 March 1972 and 31 May 1971. Figures at 31 March 1972 have not been audited, for the reason that the fiscal year of the Society does not end until 31 May 1972. The figures at 31 May 1971 have been abstracted from the report of audit dated 14 July 1971.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the ten months ended 31 March 1972 and the year ended 31 May 1971.

Revenues have been examined by the Society's

independent accountants, in full, for the period, and disbursements test-checked to approved supporting vouchers. The cash balances at 31 March 1972 were reconciled with the bank statements but were not confirmed directly with the depositories. Revenue from counties for dues assessments were checked in detail to reports on file, but were not confirmed with county treasurers at this time. Investments were not physically examined or confirmed at 31 March 1972.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities and fund balances and operating revenue and expenditures of the Society in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

### BALANCE SHEET GENERAL FUND

Assets	31 March 1972	31 May 1971
Cash (Page Tr 13) . . . . .	\$ 29,104.49	\$ 72,103.13
Certificates of Deposit (Page Tr 13) . . . . .	375,000.00	270,000.00
Investments (at cost) (Page Tr 14) . . . . .	190,245.50	190,433.00
Accounts receivable . . . . .	10,027.95	11,589.46
Inventories (at cost):		
Maternity Service Record Books . . . . .	1,697.40	2,307.48
"The Healing Art" books . . . . .	8,474.40	8,484.40
Land, buildings and equipment (contra) . . . . .	167,424.09	167,424.09
Accrued interest . . . . .	5,502.10	5,524.72
Other assets . . . . .	-----	192.74
	\$787,475.93	\$728,059.02

### 1971 TRANSACTIONS

At its first session on Saturday, 6 May 1972, the House of Delegates approved the Transactions of the 1971 House of Delegates as published in the July 1971 issue of THE JOURNAL and distributed to the membership.



# LIABILITIES AND FUND BALANCES

Liabilities:		
Unexpended budget appropriation (Page Tr 10) .....	\$111,877.15	\$ ----
Accounts payable .....	828.50	38,197.67
Payroll taxes payable .....	1,160.96	403.84
AMA collection fees payable .....	159.32	3,348.45
Deferred income—assessments collected applicable to succeeding year .....	197,785.00	227,887.91
American Medical Association (Page Tr 13) .....	72,875.00	14,960.00
Due to Physicians' Relief Fund .....	36,458.33	----
Funds for Specific Purposes:		
Membership Directory .....	7,651.49	761.07
Annual Meeting .....	18,586.46	15,000.00
Medical Journal .....	10,000.00	10,000.00
House Restoration and Replacement .....	3,339.24	1,339.24
"The Healing Art" books (contra) .....	8,474.40	8,484.40
Maternity Service Record Books (contra) .....	1,697.40	2,307.48
Land, buildings and equipment .....	167,424.09	167,424.09
General Fund Balance (Unappropriated) .....	149,158.59	237,944.87
	<u>\$787,475.93</u>	<u>\$728,059.02</u>

## PHYSICIAN'S RELIEF FUND

Due from General Fund .....	<u>\$ 36,458.33</u>	\$ ----
Physicians' Relief Fund balance .....	<u>\$ 36,458.33</u>	\$ ----

## STATEMENT OF REVENUE EXPENDITURES AND GENERAL FUND BALANCE (UNAPPROPRIATED)

	<i>Ten Months Ended 31 March 1972</i>	<i>Year Ended 31 May 1971</i>
Revenue:		
Assessments earned (Page Tr 12) .....	\$385,470.41	\$396,579.51
Interest, income, savings account, and certificates of deposit (Page Tr 13) .....	6,426.77	5,239.65
Income on Investments (Page Tr 14) .....	10,446.66	17,416.55
Maternity Service Record Book sales .....	610.08	742.92
Miscellaneous income (expense) .....	38.79	(141.40)
Total Revenue .....	<u>\$402,992.71</u>	<u>\$419,837.23</u>
Expenditures—budget appropriations .....	426,987.00	356,455.19
Excess of revenue over expenditures before Medical Journal deficit and transfers to special funds (Excess of expenditures) .....	<u>(\$ 23,994.29)</u>	<u>\$ 63,382.04</u>
Medical Journal deficit and transfer to special funds:		
Medical Journal deficit .....	\$ 29,791.99	\$ 33,428.16
Transfers to Annual Meeting Special Fund for 1971 Annual Meeting deficit .....	-----	20,222.94
Transfer to Physicians' Relief Fund .....	35,000.00	----
	<u>\$ 64,791.99</u>	<u>\$ 53,651.10</u>
Net increase in fund balance (decrease) .....	<u>(\$ 88,786.28)</u>	<u>\$ 9,730.94</u>
General Fund balance (unappropriated):		
Balance, beginning .....	\$237,944.87	\$228,213.93
Balance, ending .....	<u>\$149,158.59</u>	<u>\$237,944.87</u>

## PHYSICIANS' RELIEF FUND

Revenue:		
Transfer from General Fund .....	\$ 35,000.00	
Income from Certificates of Deposit .....	1,458.33	
Fund balance, March 31, 1972 .....	<u>\$ 36,458.33</u>	

STATEMENT OF EXPENDITURES—GENERAL FUND  
For the Ten Months Ended 31 March 1972

<i>Account</i>	<i>Adopted Budget</i>	<i>Total Expended</i>	<i>Balance Unexpended</i>
Executive Salaries . . . . .	\$ 75,693.00	\$ 63,114.46	\$ 12,578.54
General Staff Salaries . . . . .	124,960.76	101,746.32	23,214.44
General Executive Office Expenses . . . . .	18,000.00	14,035.92	3,964.08
Executive Travel . . . . .	3,300.00	2,394.39	905.61
House Maintenance . . . . .	19,600.00	15,155.81	4,444.19
Treasurer . . . . .	7,600.00	6,083.66	1,516.34
Finance and Budget Committee . . . . .	75.00	.08	74.92
Secretary . . . . .	400.00	11.00	389.00
Salary Taxes . . . . .	10,338.24	6,714.77	3,623.47
Insurance . . . . .	10,600.00	9,566.14	1,033.86
House Reserve . . . . .	8,000.00	5,896.08	2,103.92
MSNJ Pension Plan . . . . .	1,500.00	1,291.97	208.03
Legislation Council . . . . .	8,400.00	4,314.95	4,085.05
Public Health Council . . . . .	2,700.00	1,267.06	1,432.94
Public Relations Council . . . . .	7,200.00	5,017.01	2,182.99
Medical Services Council . . . . .	700.00	171.54	528.46
Mental Health Council . . . . .	1,600.00	306.39	1,293.61
President and Presidential Officers . . . . .	15,250.00	12,821.38	2,428.62
AMA Delegates . . . . .	15,110.00	11,232.08	3,877.92
Woman's Auxiliary . . . . .	3,660.00	3,109.21	550.79
Medical Education Committee and contribution to Academy of Medicine of New Jersey . . . . .	35,200.00	17,620.76	17,579.24
Conference Groups . . . . .	500.00	—	500.00
Membership Directory . . . . .	15,000.00	15,000.00	—
Emergency Medical Care Committee . . . . .	300.00	103.96	196.04
Credentials and Membership Committee . . . . .	700.00	812.21	(112.21)
Archives and History . . . . .	100.00	—	100.00
Project Hope—Vietnam . . . . .	6,000.00	1,000.00	5,000.00
Medical Defense and Insurance Committee . . . . .	500.00	153.02	346.98
Board of Trustees . . . . .	6,700.00	2,800.12	3,899.88
Contingent . . . . .	10,000.00	6,968.58	3,031.42
Judicial Council . . . . .	500.00	97.89	402.11
Legal . . . . .	7,300.00	4,312.50	2,987.50
Medical Student Loan Fund . . . . .	6,000.00	—	6,000.00
Authorized reimbursement for representatives to meetings . . . . .	3,500.00	1,990.59	1,509.41
Total Budget Expenditures . . . . .	\$426,987.00	\$315,109.85	\$111,877.15

STATEMENT OF REVENUE AND EXPENDITURES  
MEDICAL JOURNAL

	<i>Ten Months Ended</i> 31 March 1972	<i>Year Ended</i> 31 May 1971
Revenue:		
Advertising:		
State Medical Journal Advertising Bureau .....	\$37,626.67	\$43,995.27
Local .....	10,505.20	12,587.39
Cooperative Rebate .....	1,731.34	2,787.80
Classified .....	463.20	381.30
Subscriptions and Extra Copies .....	1,386.76	1,482.81
Illustrations .....	508.45	411.00
Reprints—net .....	1,816.59	361.48
Total Revenue .....	<u>\$54,038.21</u>	<u>\$62,007.05</u>
Expenditures:		
Publication .....	\$56,132.03	\$64,518.02
Salaries .....	14,961.19	16,950.00
Advertising Manager's Commission .....	4,951.40	5,338.72
Commissions—local .....	3,613.55	4,154.99
Discounts .....	875.27	984.83
Administrative Expenses .....	1,125.38	1,167.42
Payroll Taxes .....	700.56	1,020.65
Insurance .....	312.28	275.28
Travel .....	168.05	469.38
Illustration Expense .....	921.38	490.60
Office Expenses .....	69.11	65.32
Total Expenditures .....	<u>\$83,830.20</u>	<u>\$95,435.21</u>
Excess of Expenditures over Revenue .....	<u>\$29,791.99</u>	<u>\$33,428.16</u>

BALANCE SHEET  
MEDICAL STUDENT LOAN FUND

	<i>Ten Months Ended</i> 31 March 1972	<i>Year Ended</i> 31 May 1971
<i>ASSETS</i>		
Cash (Page Tr 13) .....	\$ 7,772.22	\$ 27,151.39
Certificate of Deposit (Page Tr 14) .....	160,000.00	130,000.00
Notes receivable—secured by Life Insurance Policies .....	200,414.00	199,424.00
Accrued Interest on Investments .....	754.36	915.06
Fund Balance .....	<u>\$368,940.58</u>	<u>\$357,490.45</u>

Note: The fund balance includes \$6,862.00 designated as the Albert Barker Kump Memorial Grant and \$5,079.17 designated as the Joseph E. Mott Memorial Grant.

STATEMENT OF REVENUE AND FUND BALANCE  
MEDICAL STUDENT LOAN FUND

	<i>Ten Months Ended</i> 31 March 1972	<i>Year Ended</i> 31 May 1971
Revenue:		
Contributions:		
General .....	\$ 4,375.10	\$ 5,017.30
Albert Barker Kump Memorial Grant .....	300.00	250.00
Joseph E. Mott Memorial Grant .....	15.00	34.17
Income from Investments .....	—	6,480.47
Interest on Savings Accounts and		
Certificates of Deposit (Page Tr 14) .....	6,289.87	2,158.77
Interest on Notes Receivable .....	470.16	243.98
Total Revenue .....	<u>\$ 11,450.13</u>	<u>\$ 14,184.69</u>
Bad Debt (recovery) .....	—	(50.00)
Net Revenue .....	<u>\$ 11,450.13</u>	<u>\$ 14,234.69</u>
Fund Balance, beginning .....	\$357,490.45	\$343,255.76
Fund Balance, ending .....	<u>\$368,940.58</u>	<u>\$357,490.45</u>

**SCHEDULE OF STATE ASSESSMENTS COLLECTED**  
For the Ten Months Ended 31 March 1972

<i>County</i>	<i>1972 Dues</i>	<i>1971 Dues</i>	<i>Net State Assessments</i>
Atlantic	\$ 8,040.00	\$ 742.50	\$ 8,782.50
Bergen	46,740.00	825.00	47,565.00
Burlington	8,700.00	275.00	8,975.00
Camden	24,780.00	660.00	25,440.00
Cape May	2,100.00	55.00	2,155.00
Cumberland	5,940.00	302.50	6,242.50
Essex	77,400.00	3,080.00	80,480.00
Gloucester	6,000.00	55.00	6,055.00
Hudson	2,400.00	2,420.00	4,820.00
Hunterdon	3,060.00	715.00	3,775.00
Mercer	—	2,090.00	2,090.00
Middlesex	23,160.00	550.00	23,710.00
Monmouth	20,760.00	1,705.00	22,465.00
Morris	21,600.00	467.50	22,067.50
Ocean	6,120.00	825.00	6,945.00
Passaic	35,040.00	330.00	35,370.00
Salem	2,340.00	55.00	2,395.00
Somerset	5,340.00	687.50	6,027.50
Sussex	2,460.00	55.00	2,515.00
Union	37,080.00	192.50	37,272.50
Warren	—	220.00	220.00
<b>Total</b>	<b>\$339,060.00</b>	<b>\$16,307.50</b>	<b>\$355,367.50</b>

**RECONCILIATION OF STATE ASSESSMENT ACCOUNT**  
For the Ten Months Ended 31 March 1972

Unearned Assessments, 31 May 1971	\$227,887.91
Collections, net of refunds:	
Member and Associate Dues per above	355,367.50
	<u>\$583,255.41</u>
Less 1972 assessments applicable to year ending	
31 May 1973 (7/12 of \$339,060.00)	197,785.00
Earned assessments for the ten months ended 31 March 1972	<u>\$385,470.41</u>

**SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED**  
For the Ten Months Ended 31 March 1972

<i>County</i>	<i>American Medical Association Dues</i>
Atlantic	\$ 13,915.00
Bergen	50,380.00
Burlington	13,420.00
Camden	38,775.00
Cape May	3,300.00
Cumberland	7,315.00
Essex	101,310.00
Gloucester	9,350.00
Hudson	7,260.00
Hunterdon	5,610.00
Mercer	2,530.00
Middlesex	34,705.00
Monmouth	20,460.00
Morris	30,910.00
Ocean	8,415.00
Passaic	29,920.00
Salem	3,850.00
Somerset	6,545.00
Sussex	3,410.00
Union	53,900.00
Warren	110.00
<b>Total</b>	<u><u>\$445,390.00</u></u>



RECONCILIATION OF SPECIAL ASSESSMENTS  
For the Ten Months Ended 31 March 1972

	<i>American Medical Association</i>
Balance payable, 31 May 1971 .....	\$ 14,960.00
Assessments collected per above .....	445,390.00
	<hr/> 460,350.00
Remitted to AMA .....	387,475.00
Balance payable, 31 March 1972 .....	<u><u>\$ 72,875.00</u></u>

ANALYSIS OF CASH, SAVINGS CERTIFICATES AND INCOME THEREON  
31 March 1972

General Fund:	
New Jersey National Bank:	
Treasurer's General Checking .....	\$ 14,104.49
Executive Account Checking .....	14,500.00
Office Petty Cash Fund .....	500.00
Total .....	<u><u>\$29,104.49</u></u>
Medical Student Loan Fund:	
New Jersey National Bank:	
Treasurer's Checking Account .....	<u><u>\$ 7,772.22</u></u>

ANALYSIS OF CERTIFICATES OF DEPOSIT AND INCOME THEREON

	<i>Date Due</i>	<i>Balances 31 March 1972</i>	<i>Rate of Interest</i>	<i>Interest Income</i>
General Fund:				
New Jersey National Bank:				
Certificate Number				
56213 .....		\$ 15,000.00	5 $\frac{1}{2}$ %	\$ 750.00
71146 .....	6/23/72	35,000.00	5 $\frac{1}{2}$ %	478.58
C1175 .....	4/21/72	35,000.00	4 $\frac{3}{8}$ %	439.06
C1176 .....	5/22/72	35,000.00	4 $\frac{3}{8}$ %	439.06
71170 .....	4/27/72	30,000.00	5 $\frac{1}{2}$ %	263.01
C1192 .....	7/26/72	30,000.00	4 $\frac{1}{8}$ %	213.59
C1193 .....	8/25/72	30,000.00	4 $\frac{1}{8}$ %	213.59
71176 .....	5/17/72	35,000.00	5 $\frac{1}{2}$ %	206.16
71184 .....	6/02/72	70,000.00	5 $\frac{1}{2}$ %	278.08
66397 .....	7/01/72	30,000.00	5 $\frac{1}{2}$ %	1,262.75
Income from Certificates of Deposit redeemed during period				1,761.58
First National Bank of Spring Lake:				
Number 1242 .....		15,000.00	5 $\frac{1}{2}$ %	825.00
South Jersey National Bank:				
Number 2101 .....		15,000.00	5 $\frac{1}{2}$ %	754.64
Total .....		<u><u>\$375,000.00</u></u>		<u><u>\$7,885.10</u></u>
Less Interest Income on Physician's Relief Fund .....				1,458.33
General Fund Income .....				<u><u>\$6,426.77</u></u>

# ANALYSIS OF CERTIFICATES OF DEPOSIT AND INCOME THEREON

	<i>Balances 31 March 1972</i>	<i>Rate of Interest</i>	<i>Interest Income</i>
Medical Student Loan Fund:			
Certificate Number			
66334	\$ 30,000.00	5%	\$ 1,261.11
66385	20,000.00	5%	839.80
66393	40,000.00	5%	1,683.64
71141	10,000.00	5%	143.95
71167	5,000.00	5%	48.61
71171	40,000.00	5%	357.76
Savings Account 11-1311102	15,000.00	4¼%	511.50
Total	<u>\$160,000.00</u>		
Income from investments redeemed during period			1,443.50
Total Income			<u>\$ 6,289.87</u>

# SCHEDULE OF INVESTMENTS AND INCOME EARNED 31 March 1972

<i>Description</i>	<i>Yield to Maturity</i>	<i>Cost</i>	<i>Maturity Value</i>	<i>Interest Income</i>
General Fund:				
Southern Railway Equipment Trust Certificates, due 11/1/72	6.125	\$ 19,465.00	\$ 20,000.00	\$ 1,020.64
Great Northern Railway Equipment Trust Certificates, due 3/1/73	6.00	20,000.00	20,000.00	1,000.00
Export-Import Bank Debentures due 4/30/73	6.15	20,000.00	20,000.00	1,025.00
Union Pacific Railroad Equipment Trust Certificates, due 2/1/74	7.00	20,843.00	20,000.00	1,169.86
Federal National Mortgage Association:				
Due 12/10/74	6.10	20,000.00	20,000.00	1,084.41
Due 06/10/75	5.25	20,000.00	20,000.00	876.92
Due 06/12/73	6.75	49,937.50	50,000.00	2,226.56
Federal Intermediate Credit Banks, due 7/3/72	5.55	20,000.00	20,000.00	544.34
Total Investments		<u>\$190,245.50</u>	<u>\$190,000.00</u>	
Income from investments redeemed during period				1,498.93
Total Interest from Investments				<u>\$10,446.66</u>

Approved with commendation to the Treasurer (page Tr 130)



Samuel J. Lloyd, Treasurer

# Board of Trustees

A. Guy Campo, M.D., Chairman, Westville

(Reference Committee "A")

All significant actions taken by the Board of Trustees at regular meetings held in the course of the year now closing have been reported in *The Journal* and have thus been called to the attention of the general membership. In addition, full copies of all Board minutes are transmitted to component societies, for reference and report in county society meetings. In this report, therefore, it seems necessary and desirable to emphasize by specific mention only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

Since its last report to the House, a total of eleven meetings of the Board will have been held. Attendance of members is excellent. Doctor George E. Barbour of Somerville was elected by the Board to serve as Secretary during 1971-72. Commendation is due him for his conscientious performance in processing all Board correspondence and meeting notices.

Routinely, the Board appointed representatives to local, state, and national meetings; nominated candidates to the State Board of Medical Examiners; acted on numerous reports and recommendations of the Society's councils and committees; and cooperated with allied organizations and state government.

The Board, in common with the entire medical profession of New Jersey, recorded its profound grief in the death of Jesse McCall, M.D., who rendered splendid service to The Medical Society of New Jersey, as President, Treasurer, Trustee, Chairman of the Council on Legislation, and Speaker of the House of Delegates—to name but a few of the offices which he graced. The memorial resolution adopted by the Board will be submitted as the first order of business at the 1972 House of Delegates for concurrence.

The Board of Trustees will have two more meetings before the first session of the House of Delegates. The items from those meetings which must be directed to the attention of the House will be the subject of a supplemental report.

Approved (page Tr 127)

AMA DELEGATES  
(Reference Committee "A")

The AMA Circulation and Records Department has notified the Executive Offices that as of 31 December 1971, MSNJ had 5,876 active members in the AMA. Therefore, MSNJ will be entitled to six delegates when the AMA House of Delegates is convened in June 1972.

Last year MSNJ was credited with 6,124 active members in the AMA and was entitled to seven delegates.

Approved (page Tr 127)

JOINT CONFERENCE OF PRESIDENTS AND  
PRESIDENTS-ELECT OF COMPONENT SOCIETIES  
(Reference Committee "A")

The Board continued the precedent of sponsoring, in the fall and spring, informal conferences for presidents and presidents-elect of component societies. The first conference was held on Sunday, 17 October 1971. A total of 31 presidents, presidents-elect, and other officers represented 19 component societies. The second conference was held on Sunday, 19 March 1972. A total of 28 presidents, presidents-elect, and other officers represented 19 component societies.

The various items covered informally by this group have been reported in *The Journal* and thus need not be reflected here.

Approved (page Tr 127)



EXPANSION OF HEADQUARTERS' FACILITIES  
(Reference Committee "B")

Recognizing the growing need for increased facilities at the Headquarters, at its meeting on 19 June 1966, the Board directed that the President (Joseph R. Jehl, M.D.) appoint a small committee to take the matter under advisement. (Board minutes, 19 June 1966, page 34)

The President appointed the "Committee to Investigate Future headquarters," to consist of Nicholas A. Bertha, M.D., Chairman, Samuel J. Lloyd, M.D., and Emanuel M. Satulsky, M.D. The Board approved the Committee as appointed by the President.

In succeeding years numerous acreages within the boundaries of Mercer County and up to the southern limits of New Brunswick along Route 1 were investigated. However, the Committee made no recommendation to the Board of Trustees concerning any of the sites visited.

The alternative to building new and expanded facilities in another location was to remain at the present location and enlarge the facilities there. The expanding operations of the Society made more pressing the necessity for decision and action. This circumstance was discussed in connection with the report of the Treasurer before Reference Committee "B" at the 205th Annual Meeting (May 1971), and reported to the House in that section of the reference committee report which read: "The Committee noted that the Executive Offices need additional facilities and that an assessment would be required in future years to pay for the cost thereof." The House adopted that portion of the report.

Meeting on 19 May 1971, the Board of Trustees viewed blue print sketches of an addition proposed to the present Executive Offices. After a lengthy discussion, the Board directed "That the Society proceed with the expansion of the existing Executive Offices and that the Special Committee on House Maintenance, Staff Policies, and Personnel Relations and the Executive Committee work combinedly

toward the decision of minor details." Doctor Bourns voted in the negative and asked to be so recorded. All the other members of the Board voted in the affirmative. (Board minutes, 19 May 1971, page 15) This decision of the Board to expand the existing Executive Offices was reported in *The Journal of MSNJ*, August, 1971, page 668.

Meeting on 18 July 1971, the Board of Trustees voted to discharge, with thanks, the Committee to Investigate Future Headquarters. (Board minutes, 18 July 1971, page 65)

Meeting on 21 November 1971, the Board of Trustees approved the report of the 29 October joint meeting of the Executive Committee and the Special Committee on House Maintenance, Staff Policies, and Personnel Relations, and, in so doing, approved the final building plans and contract specifications for the expansion of the Executive Offices and the bid and construction schedule as submitted. The vote of approval was unanimous. (Board minutes, 21 November 1971, pages 113-115) This action was reported in *The Journal of MSNJ*, January, 1972, page 71. In mid-January, the architect called for bids on the basis of the approved specifications.

At a meeting preceding the meeting of the Board of Trustees on 27 February 1972, the Joint Committee reviewed the accumulated bids, all of which came from union contractors, and unanimously agreed to recommend to the Board of Trustees that the lowest bidders be awarded the contracts for construction. The Committee so recommended to the Board of Trustees, and the Board unanimously approved the recommendation.

The work of construction is scheduled to begin the first week in April. A three-story addition will be built to the rear of the present structure, providing new meeting-rooms, offices, machine-rooms, storage, and toilet facilities. The parking area will not be encroached upon. The addition is expected to be ready for occupancy by mid-September.

Approved (page Tr 130)

STATEWIDE AUTOMATED BOOKKEEPING,  
ACCOUNTING, AND BILLING SYSTEM  
(Reference Committee "B")

On the recommendation of Reference Committee "B", the 1971 House of Delegates directed that, before final action is taken by the Board of Trustees, a survey of component medical societies be taken in order to inform them of the cost factors involved and the advantages accruing from the establishment of a statewide automated bookkeeping, accounting, and billing system.

During the meeting of the Board held on 19 September 1971, consideration was given to a report submitted by the Ad Hoc Committee to Establish a Statewide Automated Bookkeeping, Accounting, and Billing System. In that report the Committee presented all the accumulated data with reference to the establishment and operation of such a system. All the estimates submitted were on the basis of such a system being statewide, i.e., all component societies would participate in the program.

The Board studied the statistical data before it, including the estimates submitted by three data processing firms (Data Control Inc., Neomatics Inc., and Radnor Graphic). The Committee recommended, and the Board approved, the proposal submitted by Data Control Inc. At that time, the Board also voted to recommend to the component medical societies the proposal submitted by Data Control Inc. The Board's recommendation together with supporting informative data were sent to the presidents, secretaries, and executive secretaries of component societies on 24 September 1971.

At the Fall Conference of Presidents and Presidents-Elect of Component Societies, the Board granted permission for Mr. Barry Weiss of Data Control Inc. to address the group in order to discuss the feasibility of the Society's adopting the system.

Following the October meeting of the Board, a revised quotation was submitted by Data

Control Inc., offering a two-year contract guaranteeing an annual fee of \$1 per year, per member. However, at the Fall Conference it was concluded that the county per capita charge was not that objectionable and made little difference in attracting positive reaction.

On 21 November, the Board reviewed the results of the survey taken of the component medical societies. Results of the survey revealed that four counties, with memberships totaling 3,067 were in favor of the automated system (two of the counties voting favorably did so only on the condition that Blue Cross and Blue Shield billing would be included); thirteen counties, with memberships totaling 4,807, were not in favor of the automated system; and four counties made no reply.

Reasons why component societies showed no interest in making a change in the current billing procedure ranged from investment income earned on short term investments made from dues collected, to no specific need for such an automated system. Thus, it was the recommendation of the Committee that a statewide automated bookkeeping, accounting, and billing system not be established. The Board approved the Committee's recommendation, and the Committee was subsequently discharged with thanks.

Approved (page Tr 130)

ADOPTION OF AMA SYSTEM OF CODING  
AND NOMENCLATURE  
(Reference Committee "C")

On the recommendation of Reference Committee "C", the 1971 House of Delegates adopted, as amended, Resolution  $\pm$ 27, which directed MSNJ to call the resolution to the attention of the Medical-Surgical Plan of New Jersey and to the fiscal intermediary for the Medicare and Medicaid programs to the end that they may, as the resolution suggests, consider the feasibility of adopting the AMA system of coding and nomenclature as the universal system for description of medical services.

At its reorganization meeting, the Board referred the resolution to the President of Medical-Surgical Plan of New Jersey and to the General Manager of the Prudential Insurance Company of America.

**Approved (page Tr 131)**

CONTINUANCE OF MSP-HSP COVERAGE FOR  
CHILDREN OF SUBSCRIBER PHYSICIANS  
(Reference Committee "C")

Resolution #31—as adopted in amended form by the House of Delegates—called upon MSNJ to recommend to the Boards of Trustees of both the Medical-Surgical Plan of New Jersey and the Hospital Service Plan of New Jersey the continuance of group coverage of subscriber physicians' dependent children through four years of college.

Plan officials have supplied the following information concerning two basic options available to group members of medical societies with respect to covering children beyond age 19:

(1) If the dependent is a full-time student at the time of the 19th birthday, he may transfer directly to individual student coverage which is offered at a substantially lower rate than regular non-group coverage. This does not require a health statement. If the dependent is beyond age 19 and is a full-time student and had not previously elected to enroll with Blue Cross/Blue Shield in any coverage, enrollment is made available during Open Seasons in September and February and this does not require a health statement.

(2) If the group wishes to make coverage available to all children from age 19 to 23 or 25, and if the group is enrolled under a Domestic Master Contract, coverage can be extended to all the group subscribers holding Family or Parent and Child Coverage. This extension of dependency age would require a slightly higher premium and this would be applied to all Family or Parent and Child subscribers.

These options, in addition to the regular direct payment coverage available without health statement at age 19 for those who are not full-time students, constitute an adequate range of opportunity for continuous coverage for dependents age 19 and over.

**Approved (page Tr 131)**

COMMITTEE ON EXTENSION TO INTERNS AND  
RESIDENTS OF POWER TO SIGN CERTAIN  
LEGAL DOCUMENTS  
(Reference Committee "E")

At its meeting held on 19 May 1971, the Board directed that a letter be sent to the Secretary of the State Board of Medical Examiners asking for further clarification of the 1970 opinion from the Attorney General that prescriptions signed by interns and residents of the Martland Medical Center in Newark may be legally filled in retail pharmacies—in all other areas of the State this privilege does not apply.

Under date of 27 July 1971, the Secretary of the State Board of Medical Examiners informed MSNJ that he was referring the question to the Attorney General for an opinion.

The Attorney General's reluctance to issue an opinion may be found in a statement which was communicated to the Society from his office. That statement reads as follows:

"In accordance with State law, N.J.S.A. 52:17A-4(e), the Attorney General is only authorized to render legal advice to State departments and agencies. He is not empowered to render advice to governmental instrumentalities, private citizens, or corporations."

**Approved (page Tr 135)**

CRASH PROGRAM ON BLOOD PROCUREMENT  
(Reference Committee "E")

Aware that donations to blood banks throughout the State fall to their lowest level during the month of December each year, the Board of Trustees authorized the insertion of a paid advertisement titled, "It is more blessed to give than to receive," in all daily newspapers to urge the people of New Jersey, in the spirit of the holiday season, to give blood to their local blood banks. This program was implemented under the guidance of the public relations firm of Daniel Edward, Inc.

The idea of an ongoing, year-round program of blood procurement was also referred to the Council on Public Relations for adoption as a regular continuing project.

**Approved (page Tr 135)**



**MSP BOARD OF TRUSTEES—NOMINATIONS**  
(Reference Committee "C")

The following nominations were approved by the Board and are referred to the House of Delegates for action:

Not included in this printed list of members serving on the Board of Trustees are the following: Chairman of the Board of Trustees of Hospital Service Plan of New Jersey, and the

President of The Medical Society of New Jersey. These individuals serve during their respective terms of office of the organization indicated.

Also listed are persons that will continue membership on the Board until the expiration of their terms in the year indicated—or until their successors are elected and qualified:

Three-year term (1972-1975):

<i>Name</i>	<i>Type of Practice</i>	<i>Member of Component Society</i>
Donald T. Akey, M.D.	Surgeon	Middlesex County
Robert G. Boyd	Hospital Administrator	---
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cuniff, M.D.	Internist	Hudson County
Andrew P. Dedick, M.D.	Radiologist	Monmouth County
Warren H. Simmons, Jr.	Businessman	---
Sidney I. Simon, Ph.D.	College Professor	---
Morgan Sweeney	Labor Leader	---
Robert E. Verdon, M.D.	General Practitioner	Bergen County

One-year term (1972-1973):

<i>Name</i>	<i>Type of Practice</i>	<i>Member of Component Society</i>
John J. McGuire, M.D.	Surgeon	Essex County
Walter Miller, D. O.	Osteopath	---

Terms expiring 1973:

<i>Name</i>	<i>Type of Practice</i>	<i>Member of Component Society</i>
Edgar P. Eaton, Jr.	Businessman	---
Mortimer J. Fox, Jr.	Businessman	---
*Jerome G. Kaufman, M.D.	Internist	Essex County
Joseph M. Keating, M.D.	Obstetrician	Passaic County
Henry J. Mineur, M.D.	Internist	Union County
Stanley C. Van Ness	Lawyer	---
John F. Waters	Labor Leader	---

Terms expiring 1974:

<i>Name</i>	<i>Type of Practice</i>	<i>Member of Component Society</i>
Edwin H. Albano, M.D.	Pathologist	Essex County
James T. Crowley	Businessman	---
Lloyd M. Fehnly	Retired Newspaper Editor	---
John Kelley	Labor Leader	---
Samuel J. Lloyd, M.D.	Medical Consultant	Mercer County
Theron L. Marsh	Banker	---
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County
Thomas J. White, M.D.	Internist	Hudson County

\*deceased

Approved (page Tr 131)

**PROBLEMS AFFECTING INTERNSHIPS AND  
RESIDENCIES IN NEW JERSEY HOSPITALS**

(Reference Committee "D")

At the 1971 Annual Meeting, the House of

Delegates adopted, as amended by Reference Committee "D", Resolution #44 (Problems Affecting Internships and Residencies in New Jersey Hospitals). The "resolveds" of the resolution read as follows:

RESOLVED, that The Medical Society of New Jersey reaffirm its stand requiring E.C.F.M.G. certification of interns, and that the Board of Trustees continue to work for repeal of Chapter 112, P.L. 1971 (formerly Assembly Bill No. 2131); and be it further

RESOLVED, that The Medical Society of New Jersey take note of this situation and request the American Medical Association through its Council on Graduate Medical Education to explore all possible means of resolving this untenable situation.

The established policy of the AMA with reference to the eligibility of foreign medical graduates for appointment to approved internships and residencies was revised on 23 June 1971 as follows:

(1) A new pathway for entrance to AMA approved internship and residency programs, other than those existing under previous AMA policies, is available as of July 1, 1971, for students who have fulfilled the following conditions:

(a) have completed, in an accredited American college or university, undergraduate premedical work of the quality acceptable for matriculation in an accredited U.S. medical school,

(b) have studied medicine at a medical school located outside the United States, Puerto Rico, and Canada, but which is recognized by the World Health Organization,

(c) have completed all of the formal requirements of the foreign medical school except internship and/or social service.

(2) Students who have completed the academic curriculum in residence in a foreign medical school and who have fulfilled the above conditions may be offered the opportunity to substitute for an internship required by a foreign medical school, an academic year of supervised clinical training (such as a clinical clerkship or junior internship) prior to entrance into the first year of AMA approved graduate medical education. The supervised clinical training must be under the direction of a medical school approved by the Liaison Committee on Medical Education.

(3) Before beginning the supervised clinical training, said students must have their academic records reviewed and approved by the medical schools supervising their clinical training and must pass a screening examination acceptable to the Council on Medical Education, such as Part I of the National Board examinations, or the ECFMG examination, or the FLEX examination.

(4) Said students who are judged by the sponsoring medical schools to have completed successfully the supervised clinical training are eligible to enter the first year of AMA approved graduate training programs without completing social service obligations required by the foreign country or obtaining ECFMG certification.

(5) The Council on Medical Education will recommend to all state boards of medical examiners that they consider for licensure all candidates who have completed successfully the supervised clinical training on the same basis as they now consider foreign medical candidates who have received ECFMG certification.

Approved (page Tr 133)

#### SAMA's MECO PROJECT (Reference Committee "D")

The Student American Medical Association considers health manpower distribution and the isolation of medical students in specialty-oriented university medical centers as two specific problems in improving health care delivery in the United States. To combat these, SAMA has developed the Medical Education and Community Orientation (MECO) Project, which places pre-clinical students in communities for summer education experiences. It is SAMA's conviction that if students are exposed to the community and to community medicine before they have made a decision to specialize, they will be able to make a more knowledgeable decision about their eventual type of practice and their geographic location. The New Jersey State Project Director of MECO requested that the Society endorse the project, which will be initiated in New Jersey during the summer of 1972.

Meeting on 19 December, the Board unanimously agreed to endorse the MECO Project and to refer the entire matter to the Standing Committee on Medical Education for implementation.

Approved (page Tr 133)

#### LEGISLATION TO PROVIDE THAT BLOOD TRANSFUSING IS A SERVICE NOT A SALE (Reference Committee "E")

Resolution #10—as adopted in amended form by the House of Delegates—called upon MSNJ to urge enactment of S-752 at the earliest possible time.

S-752 was introduced in the 1970-71 Legislature by Senators Wallwork, Matturi, Giuliano, Del Tufo, and Dowd. It provided that human blood, blood plasma, tissues, or organs shall not be considered commodities subject to sale or barter. The Society's position on the measure was "active support."

In an effort to work out a pattern of support acceptable to the sponsors, a conference was held with Senator Wallwork, chief sponsor of the measure, together with representatives of

the New Jersey Hospital Association and the New Jersey Blood Bank Association. Senator Wallwork indicated that in his view the climate was not favorable to move the bill and that a substitute measure, expanded to include broader elements affecting blood-banking procedures in general should be prepared. In consequence, the bill was not moved and died at the close of the 1971 Session. The Society succeeded in having the measure re-introduced by Senator Crabel in the 1972 Session as S-789. A program of active support has been launched and all keymen and members of MSNJ, and all cooperating agencies, have been called upon to contact legislators, in both the State Senate and Assembly, to effectuate enactment of the bill. As this report is being compiled, that campaign is actively being pursued.

Approved (page Tr 135)

#### LEGISLATIVE APPROACH TO PROFESSIONAL LIABILITY

(Reference Committee "E")

The 1971 House amended and adopted Resolution #24, submitted by Essex County, on the subject of "Legislative Approach to Professional Liability." The resolution called upon the Board of Trustees to appoint "An ad hoc committee to consider all items listed in the resolution from (a) through (o) and to work toward introduction of as many legislative measures as the legislature will accept."

Accordingly, the Board appointed the "Ad Hoc Committee to Evaluate Legislative Solutions to Professional Liability." Its personnel consists of Meyer L. Abrams, M.D., Chairman, George L. Benz, M.D., and Paul J. Kreutz, M.D. Mr. E. Powers Mincher, Legal Counsel, and Mr. Vincent A. Maressa, Executive Assistant, have been assigned to assist and advise the Committee.

As the first results of its endeavors, the Committee submitted to the Board of Trustees (27 February 1972) drafts of seven pieces of legislation which it had prepared. It recommended that the drafts be transmitted to the Council on Legislation for immediate introduction

in accordance with the Council's established procedure. At the time of this writing, the Council on Legislation is in process of seeking legislative sponsors for the seven bills.

Approved (page Tr 135)

#### RESCINDING OF EYE MEDICATION RULING (Reference Committee "E")

Meeting on 19 May 1971, the Board of Trustees directed that Resolution #12, calling for the introduction of legislation to prevent optometrists from using eye medication for diagnostic purposes, be referred to the Conference Committee on the Control of Eye Medication for early consideration, and that, upon receipt of a report from that Committee, Resolution #12 then be referred to the Council on Legislation for the preparation of an appropriate bill for introduction into the Legislature.

Prior to the 15 December 1971 meeting of the Conference Committee on the Control of Eye Medication, MSNJ's Legislative Analyst drafted legislation for review by the Committee. The proposed draft would amend R.S. 45:12-1.

Representatives of the New Jersey Academy of Ophthalmology and Otolaryngology who were present at the Committee's meeting indicated that they approved the legislation as drafted. It was therefore agreed that the Academy would notify the Executive Director when it had found a sponsor willing to introduce a bill into the 1972-1973 Legislature.

Approved (page Tr 135)

#### USE OF PHYSICAL THERAPY MODALITIES BY CHIROPRACTORS (Reference Committee "E")

During the 19 December meeting of the Board, the Executive Director called attention to the fact that the Secretary of the State Board of Medical Examiners in the Division of Consumer Affairs of the Department of Law and Public Safety, pursuant to authority of N.J.S.A. 45:9-2, proposed to adopt a new rule relating to the use of physical therapy modalities by chiropractors.



The full text of the proposed rule, which appeared in the *New Jersey Register*, Volume 3, No. 12, under date of 9 December 1971, reads as follows:

"Physical therapy measures and modalities as defined by N.J.S.A. 45:9-37.1 (b) may be utilized by a Chiropractor provided that such measures and modalities may be employed only in preparing a patient for and as an essential aid to Chiropractic manipulative therapy. Physical therapy may be administered, at the specific direction of a Chiropractor, by a Registered Physical Therapist provided that such physical therapy services shall be limited to preparing a patient for and as an essential aid to Chiropractic manipulative therapy."

Under date of 9 December 1971, the Executive Director sent the following letter to the Secretary of the State Board of Medical Examiners:

The Medical Society of New Jersey is vitally concerned with the health and safety of the citizens of New Jersey. Being dedicated to the rendition of quality health care services to the public, we are therefore availing ourselves of the opportunity to present our opposition to the proposed rule on "Use of Physical Therapy Modalities by Chiropractors" as published in 3 NJR 260 (c).

N.J.S.A. 45:9-37.7 (h) clearly indicates that a physical therapist may only treat or undertake treatment of a human being pursuant to the prescription or oral direction of a duly licensed physician. A chiropractor is not, under New Jersey law, a duly licensed physician.

N.J.S.A. 45:9-14.5 defines the practice of chiropractic as "A system of adjusting the articulations of the spinal column by manipulation thereof." That definition, as you know, nowhere even remotely approaches a similarity to that of physical therapy under N.J.S.A. 45:9-37.1 (b).

N.J.S.A. 45:9-21 (k) declares that the statutory exemption of ancillary personnel does not apply to assistants of persons licensed as "osteopaths, chiropractors, optometrists, or other practitioners holding limited licenses."

The legislative intent and definition in the aforementioned statutes make it patently and readily observable that chiropractors are to restrict their activities to adjusting articulations of the spinal column by means of manipulation thereof, and that they may not prescribe or direct the services of a registered physical therapist.

The proposed rule is an attempt by the State Board of Medical Examiners to amend present well-established statutory law by means of an administrative rule diametrically opposed to the clearly established intent of the Legislature. We urge you, therefore, not to adopt the proposed rule.

The Board recorded itself unanimously as affirming and completely agreeing with the letter of 9 December, addressed by the Executive Director of MSNJ to the Secretary of the State Board of Medical Examiners, expressing

strong opposition to the State Board's proposed rule, and decided, by official communication, to so inform the State Board and to request permission to discuss the proposed new rule at the next meeting of that body.

The Board further directed that a copy of the aforementioned official communication to the Secretary of the State Board be transmitted to the Attorney General and the Commissioner of Insurance of New Jersey, and that the entire matter be brought to the attention of all component societies, all specialty societies, and the Health Insurance Council to stimulate them to register similar protests.

On 6 January 1972, the Executive Director telephoned the Secretary of the State Board of Medical Examiners and was informed that there had been such a reaction of opposition from all areas and groups, including chiropractors, that the proposed rule had no chance of adoption. In view of that circumstance, the Secretary of the State Board regarded it as unnecessary to invite representatives of the Society to attend the State Board meeting on 12 January 1972. The Executive Director was assured by the Secretary of the State Board that if by any chance further favoring interest in the proposal should develop, the matter would be laid over for another month and representatives of MSNJ and other groups would then be invited to come in to present their arguments of opposition.

**Approved (page Tr 135)**

AD HOC COMMITTEE TO STUDY AND MAKE  
RECOMMENDATIONS CONCERNING THE  
FOUNDATION APPROACH TO  
MEDICAL CARE  
(Reference Committee "F")

At its meeting on 19 March 1972, the Board of Trustees authorized the establishment of the Ad Hoc Committee to Study and Make Recommendations Concerning the Foundation Approach to Medical Care. The Committee's personnel consists of the following:

Richard E. Lang, M.D., Passaic, Chairman  
Louis F. Albright, M.D., Spring Lake  
George L. Benz, M.D., Newark  
William J. D'Elia, M.D., Neptune City  
James S. Todd, M.D., Ridgewood

Approved (page Tr 137)

APPROVAL CRITERIA OF JOINT COMMISSION ON  
ACCREDITATION OF HOSPITALS  
(Reference Committee "F")

Resolution #13 (Passaic County) of the 1971 House of Delegates called upon MSNJ to instruct its delegates to the AMA to petition the AMA to investigate the method of survey and approval of the Joint Commission on Accreditation of Hospitals so as materially to enhance the emphasis on plant and equipment status of an institution in its approval survey.

In furtherance of the indicated wishes of MSNJ's House of Delegates, at the AMA's 1971 Annual Convention, the New Jersey Delegation introduced Resolution #63 in the AMA House of Delegates. Resolution #63 was adopted, on recommendation of Reference Committee "D," which reported: "Testimony indicated that to a large degree the intent of Resolution #63 will be achieved. The Joint Commission in implementing its revised standards, effective 1 July 1971, will place increasing emphasis on hospital plant and equipment."

Approved (page Tr 137)

BACCALAUREATE PROGRAM FOR PHYSICIANS'  
ASSOCIATES  
(Reference Committee "F")

At the 1971 Annual Meeting, the House of Delegates voted to record MSNJ as disapproving the four year "Baccalaureate Program for Physicians' Associates" offered by the Livingston College of Rutgers University.

Under date of 11 June 1971, the Board of Trustees called the action of the House to the attention of the Deans of New Jersey's medical schools so that they would be aware of the Society's position with reference to this particular degree program.

Approved (page Tr 137)

CRITERIA USED BY FISCAL INTERMEDIARIES IN  
REVIEWING PHYSICIANS' SERVICES  
(Reference Committee "F")

Among the items dealt with by Reference Committee "F" at the 1971 Annual Meeting, the House of Delegates approved that section of the report of the Board of Trustees dealing with "Criteria Used by Fiscal Intermediaries in Reviewing Physicians' Services." In conjunction with its recommendation that this portion of the report be approved, the Reference Committee urged the fiscal intermediary to notify the physicians of their policy changes by direct and prompt communication.

In compliance with the directive of the House, the Secretary of the Board sent a communication to James E. Brennan, M.D., Medical Director of the Governmental Health Programs Department, Prudential Insurance Company of America, informing him of the action taken.

Approved (page Tr 137)

LIAISON COMMITTEE WITH FISCAL  
INTERMEDIARIES  
(Reference Committee "F")

On the recommendation of Reference Committee "F", the 1971 House of Delegates adopted Resolution #39, which called upon MSNJ to establish state and county committees to communicate with the fiscal intermediary on behalf of member physicians, in order to insure that medical judgment is given adequate consideration.

MSNJ has been informed that final determination of any claim by the fiscal intermediary is made by the Medical Director or one of the physicians serving under him.

Approved (page Tr 137)

SPECIAL COMMITTEE TO ASSIST EXISTING  
GOVERNMENTAL HEALTH PLANNING AGENCIES  
(Reference Committee "F")

In accordance with a suggestion originating with the Special Committee on Child Health and approved by the Council on Public Health, the following recommendation was

adopted by the Board of Trustees at its meeting on 21 November 1971:

That the Board of Trustees of MSNJ establish a special committee whose primary aim would be to assist existing governmental health planning agencies in their activities.

The President has appointed the following physicians to serve on the Committee:

Harold L. Colburn, Jr., M.D., Moorestown, *Chairman*  
I. Edward Ornaf, M.D., Cherry Hill  
James S. Todd, M.D., Ridgewood

The action taken by the Board of Trustees in establishing this Committee will also accomplish the intent of Resolution #21 from the 1971 Annual Meeting, which called upon MSNJ to place increased emphasis on seeking direct Society representation on all governmental planning councils and agencies.

**Approved (page Tr 137)**

STATE PEER REVIEW COMMITTEE  
(Reference Committee "F")

The 1971 House of Delegates adopted Resolution #16, submitted by the Essex County Medical Society, which called upon MSNJ to establish a Peer Review Committee following the guidelines contained in the "Peer Review Manual" of the AMA's Council on Medical Service and also that the Society direct its component societies to do likewise.

At its meeting on 18 July 1971, the Board of Trustees directed that the Special Committee on Long Range Planning and Development call a meeting of all interested councils and committees to discuss the peer review problem in detail and report the results of the meeting to the Board.

A Joint Meeting of the Special Committee on Long Range Planning and Development with the Judicial Council, Council on Medical Services, and Committee on Medical Education was held on 12 September 1971, and the following recommendation was submitted to, and approved by, the Board of Trustees:

"That the Board of Trustees appoint a State Peer Review Committee consisting of at least five members, with an alternate for each member and with each judi-

cial district being represented. The committee shall be given the authority to call consultants. Also, the Peer Review Committee is to be directed that its first responsibility is to devise guidelines for operation of peer review committees at State and county levels. Further, that the Board direct component medical societies to form peer review committees, subject in operation to the guidelines later to be supplied."

At the direction of the Board, the President and Chairman of the Board appointed the following members of the State Peer Review Committee:

*First District*

George L. Benz, M.D. (Chairman)  
Hillel M. Ben-Asher, M.D., (alternate)

*Second District*

Thomas C. DeCecio, M.D.  
James A. Rogers, M.D. (alternate)

*Third District*

John A. Lincoln, M.D.  
Karl T. Franzoni, M.D. (alternate)

*Fourth District*

William R. Muir, M.D.  
Earl B. Keller, M.D. (alternate)

*Fifth District*

Louis K. Collins, M.D.  
Sherman Garrison, M.D. (alternate)

*Consultants:*

Louis F. Albright, M.D.  
Secretary of The Medical Society of New Jersey, Chairman of the Special Committee on Long Range Planning and Development, and Chairman of the Joint Ad Hoc Task Force with the New Jersey Hospital Association

Arthur Bernstein, M.D.  
Serves as a member of the Ad Hoc Task Force with the New Jersey Hospital Association and member of the Committee on Medical Education

John S. Madara, M.D.  
Serves as Chairman of the Judicial Council and member of the Council on Legislation

Nicholas F. Marchione, M.D.  
Serves as a member of the Board of Trustees, Joint Ad Hoc Task Force with the New Jersey Hospital Association, Consultant to the Council on Medical Services and member of the State Health Planning Council

Mr. Jack Owen, President, New Jersey Hospital Association serves on the Joint Ad Hoc Task Force with the New Jersey Hospital Association

James A. Rogers, M.D.  
Second Vice-President of The Medical Society of New Jersey serves as Chairman of the Committee on Medical Education

**Approved (page Tr 137)**



SUPPORT OF HMO CONCEPT  
(Reference Committee "F")

On the recommendation of Reference Committee "F", the 1971 House of Delegates adopted Resolution #43. The subject of the resolution dealt with the support of the HMO concept. The final "resolved" of the resolution reads as follows:

RESOLVED, that The Medical Society of New Jersey express its agreement with the concept of a need for some changes in the delivery of health care services, and that The Medical Society of New Jersey provide ethical guidelines consistent with legal aspects where appropriate and pertinent.

Meeting on 19 May 1971, the Board of Trustees directed that a communication be addressed to the sponsor of the resolution requesting that he provide specific direction as to the types of ethical questions he feels should be dealt with. The Board was of the opinion that if the Society is to provide ethical guidelines it would have to have more specifics as to the areas of ethical activities involved.

Under date of 11 June 1971, the Secretary of the Board of Trustees addressed a communication to the sponsor of the resolution calling the Board's action to his attention. As of this writing, no reply has been forthcoming.

Approved (page Tr 137)

FDA POLICY ON FIXED COMBINATION DRUGS  
(Reference Committee "G")

At the 1971 Annual Meeting, the House of Delegates adopted Resolution #32 (FDA Policy on Fixed Combination Drugs). The "resolved" portion of that resolution reads as follows:

RESOLVED, that The Medical Society of New Jersey urge the Federal Drug Administration to reconsider its action of categorically removing all fixed combination drugs from the market; and be it further

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the House of Delegates of the American Medical Association to introduce a resolution to induce the American Medical Association to take like action.

During the AMA Annual Convention in June 1971, the New Jersey Delegation supported

those resolutions before the AMA House opposing the FDA regulation against combination drugs, particularly Resolution #12, introduced by the Nevada Delegation, and Resolution #14, introduced by the Connecticut Delegation. The AMA House adopted the following resolution as a substitute for Resolutions 12, 14, 45, and 87:

RESOLVED, that the American Medical Association recommend that any Congressional Committee authorized to investigate or act upon matters relating to the operation and activities of the Food and Drug Administration include within such investigation and consideration the question of the FDA's basing regulatory action on controversial scientific studies.

A copy of MSNJ's Resolution #32 was also forwarded to Charles Edwards, M.D., Commissioner of the United States Food and Drug Administration, Department of Health, Education, and Welfare.

Under date of 1 July 1971, John Jennings, M.D., Associate Commissioner for Medical Affairs made the following reply:

There has been widespread misunderstanding about the FDA policy on combination drugs. To correct this, and to be helpful to the physician, we have recently mailed to the approximately 300,000 physicians in the U.S. the enclosed copy of the "FDA Drug Bulletin," which explains our policy on fixed combination prescription drugs and other policy matters.

Your Society's resolution urges that the Food and Drug Administration reconsider its action of categorically removing all fixed drugs from the market. We wish to assure your Society that it is not, nor has it ever been, FDA's policy of intention that drug combination should be banned by across-the-board actions. We are not against fixed dose combinations. There is now, and always will be a place for good combination drugs. The FDA policy on drug combination is: that more than one drug should not be used when one is all that is needed; that drugs in fixed combination should provide safe and effective therapy for a population of patients who require concomitant treatment by the two or more drugs in the combination; that the dose of such components be appropriate for the intended patient population that can be defined in the labeling for the drug. A special case of this general rule is the addition of ingredients that enhances the safety or effectiveness of the principal active component or minimizes its abuse potential.

We believe the above requirements are reasonable, and, if followed, will bring about better therapeutics and the availability of better drugs. The Council on Drugs of the American Medical Association, the Council on Drugs of the American Pediatrics Association, the American Pharmaceutical Association, the *United States Pharmacopeia*, leading textbooks, and the leaders of the medical profession have consistently expressed the need for a sound medical rationale for using drugs in fixed combination.

The FDA shares your Society's concern that the agency secure the judgment of the practicing physicians before condemning or removing drugs from the market. Before proposing our policy on fixed combination prescription drugs, we did consult with many knowledgeable practicing physicians. Since the proposal has been published, we have heard from a great many other physicians, and have considered all the views received. Most agree that drug effectiveness has to be evaluated on the basis of controlled studies, whether they be carried out in the physician's practice, or in a medical center. What we ask, and what the law requires, is that claims of effectiveness be supported by evidence derived from adequate clinical investigations on the basis of which it can be concluded responsibly that any drug will have the effectiveness it is represented to have, and which it purports to possess. Evidence meeting these standards that can be contributed by a practicing physician is not only utilized, it is eagerly sought.

Approved (page Tr 139)

#### MINIMUM EYE EXAMINATION (Reference Committee "G")

At the 1971 Annual Meeting, the House of Delegates adopted two resolutions (#34 and #37) opposing the proposed rule of "Minimum Eye Examination."

In accordance with the directive of the House, the Executive Director sent a communication to the Secretary of the State Board of Medical Examiners requesting permission for representatives of the Society to appear before the State Board at its 9 June 1971 meeting, to the end that those representatives would enlarge upon the Society's case in opposition to the proposed rule and discuss with members of the State Board some authoritative means, other than through adoption of the rule as proposed, of dealing with the situation in New Jersey that led the State Board to consider the adoption and promulgation of said rule.

On 9 June 1971, representatives of MSNJ appeared before the State Board of Medical Examiners to discuss the proposed rule. The members of the State Board seemed to understand the points of opposition, which were recapitulated by the ophthalmologists present. Also emphasized was the fact that by making this specific rule the State Board would set a precedent under which it could impose similar rules upon all phases of medical and surgical practice.

It was made clear that the State Board, in the public interest, is concerned to have some means of controlling the present slack examination procedures being indulged by certain licensed physicians in the employ of commercial groups engaged in supplying corrective lenses to the public.

As an alternative to the proposed rule, representatives of MSNJ offered the following for the consideration of the State Board:

All services rendered by a physician licensed to practice medicine and surgery in the State of New Jersey shall meet or surpass the prevailing accepted norms of the practice of medicine and surgery.

It was pointed out that this would give the State Board the opportunity of utilizing the principle of peer review to evaluate any and all types of medical and surgical practice alleged to be less than professionally adequate and satisfactory.

On 15 June 1971, the Secretary of the State Board of Medical Examiners informed MSNJ that the State Board voted to disapprove the proposed rule on "Minimum Eye Examination," as published in the *New Jersey Register*.

Approved (page Tr 139)

#### SMALLPOX VACCINATION (Reference Committee "G")

At its meeting on 17 October, the Board of Trustees met with Ronald Altman, M.D., Director of Epidemiologic Services of the New Jersey State Department of Health, to discuss the new U.S. Public Health Service policy on smallpox vaccination.

Doctor Altman requested that the Board support the following recommendation of the United States Public Health Advisory Committee concerning the administration of smallpox vaccine:

Because of the rapidly declining incidence of smallpox in the world and the vastly reduced risk of its being imported into the United States, health officials in the United States should consider the discontinuation of compulsory measures as they relate to routine smallpox vaccination.

The Board voted unanimously to support the recommendation and the New Jersey State Department of Health was so informed.

**Approved (page Tr 139)**

TRANSFUSION-ASSOCIATED HEPATITIS  
(Reference Committee "G")

At the direction of the Executive Committee of MSNJ, and with the approval of the Society's Board of Trustees, the President addressed a memorandum (December 28, 1971) to all chiefs of staff of New Jersey hospitals, with copies to the hospital administrators and the heads of the departments of pathology, supporting the informational data and recommendations contained in a letter that was sent to all physicians of New Jersey by the State Commissioner of Health concerning transfusion-associated hepatitis.

It was the opinion of the Executive Committee and the Board of Trustees that all physicians should carefully evaluate their use of one and two unit transfusions. Accordingly, request was made that this matter be placed on the agenda for the general staff meeting at all New Jersey hospitals and on the agendas for all departmental meetings, and that discussion of this item be recorded in the minutes of such meetings. It was likewise suggested that an internal audit committee (such as a transfusion or tissue committee) be assigned the task of reviewing records of one and two unit transfusions.

On 12 January 1972, the Board of Trustees of the New Jersey Hospital Association voted to endorse MSNJ's position and to urge all member hospitals to call this matter to the attention of their organized medical staffs.

**Approved (page Tr 139)**

UNIFORMITY OF BLOOD BANKING PROCEDURES  
IN NEW JERSEY  
(Reference Committee "G")

The Medical Society of New Jersey along with the New Jersey Hospital Association, the New Jersey State Department of Health, and the New Jersey Blood Bank Association is vi-

tally concerned with the acquisition and maintenance of an adequate supply of blood and blood derivatives for the seriously ill in New Jersey. All of the aforementioned groups agree that some definitive action must be taken on the State level. Therefore, at its 21 November 1971 meeting, the Board of Trustees unanimously approved the following recommendations:

(1) That the Governor of New Jersey be requested to establish a Commission to study problems relating to the procurement and distribution of blood in the State of New Jersey.

(2) That upon appointment of the above-mentioned Commission, MSNJ schedule a meeting to prepare testimony for presentation to that Commission. To this meeting should be invited agencies connected with blood collection.

Under date of 30 November 1971, the Secretary of the Board of Trustees called the Society's views to the attention of the Governor of New Jersey.

**Approved (page Tr 139)**

COMMITTEE ON RESOLUTIONS  
(Reference Committee "H")

At its meeting on 18 July 1971, the Board of Trustees approved a recommendation, submitted by the Committee on Annual Meeting, which called for the establishment of a Committee on Resolutions.

The functions of the Committee are: (1) to review all resolutions in advance of the annual meeting; (2) with the cooperation of the sponsors, to combine resolutions containing duplication of subject matter; and (3) to determine whether or not the resolutions received after the deadline date are, in fact, of an emergency nature.

Meeting on 27 February 1972, the Board named the three most recent past presidents of the Society (Doctors Emanuel M. Satulsky, Nicholas A. Bertha, and John F. Kustrup) to serve on the Committee. Doctor Satulsky was designated the Chairman.

**Approved with notation (page Tr 141)**



AFFILIATE OR ADJUNCT MEMBERSHIP IN MSNJ  
(Reference Committee on Constitution and Bylaws)

At the request of the Standing Committee on Medical Defense and Insurance, the Board, at its 21 November 1971 meeting, approved the following recommendation for referral to the Standing Committee on Revision of Constitution and Bylaws:

That MSNJ create a new category of special continuing membership, such as "affiliate" or "adjunct," to enable former active members of MSNJ who leave the State to retain membership status with the Society and thereby continue their coverage under its group health, accident, and life insurance policies.

Approved (page Tr 142)

Judicial Council

John S. Madara, M.D., Chairman, Salem  
(Reference Committee "A")

From official findings, the Judicial Council here presents a summary of its operations and those of county judicial committees for the period 17 May 1971 through 12 March 1972.

BY JUDICIAL COMMITTEES

Complaints reported as disposed of . . . . .36

Alleging: . . . . .  
Dissatisfaction concerning fees . . . . . 15  
Unethical conduct . . . . . 2  
Unprofessional conduct . . . . . 19

BY THE JUDICIAL COUNCIL

Meetings held . . . . . 5  
Official communications acted upon . . . . .28  
Appeal hearings requested . . . . . 6  
Appeals hearings granted . . . . . 2  
Formal opinions rendered . . . . . 1

ETHICAL ACCEPTABILITY OF CERTAIN  
BILLING PROCEDURES  
(Adopted 26 September 1971)

This opinion was forwarded to chairmen of Judicial Committees of all component societies and is presented in full:

At the request of the Chairman of the Judicial Committee of a component society, the

Judicial Council reviewed a statement issued in the name of the Judicial Ethics Committee of the New Jersey State Society of Anesthesiologists, Inc. under date of 22 April 1971, and circulated to "Judicial Ethics Committees of Every County Medical Society."

The statement follows:

Recent review of a complaint against a member of the New Jersey State Society of Anesthesiologists, Inc., by this committee as regards billing practice of employing agency to handle sole responsibility of collections; we find no evidence of unethical conduct. How a physician handles his private billing is a personal matter. Each physician has to conduct his billing satisfactory to him. Because a Medical Society group does not think it so, they may have to question Public Relations and not Ethics.

The Judicial Council disagrees with that statement, particularly the sentences: "How a physician handles his private billing is a personal matter. Each physician has to conduct his billing satisfactory to him."

Section 4, Chapter 1, of the Bylaws of The Medical Society of New Jersey, under the caption, "Rules of Conduct" declares:

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of members in all categories of The Medical Society of New Jersey in their relation to each other and to the public.

Interpretation and enforcement of those principles are vested at national level in the Judicial Council of the American Medical Association and in New Jersey in the Judicial Council of The Medical Society of New Jersey and the Judicial Committees of the component societies.

In fulfillment of its function, MSNJ's Judicial Council, on 23 February 1969, considered a question submitted by the judicial committee of a component society which asked: "Is it proper for a physician who does not require office space, such as an anesthesiologist, to place his billing service with a collection agency, and for his letterhead to use his name but the agency's address?"

The Council in response declared:

The Judicial Council of the American Medical Association has been seriously concerned with billing practices utilizing collection agencies. The members of the Judicial Council of The Medical Society of New Jersey agree with the AMA Judicial Council that such a procedure is neither professional nor becoming to physicians. It misleads patients and does not permit a patient who has received a bill bearing such an address to contact the physician without going through the collection agency. A third party not steeped in the traditions of medical practice enters in the physician-patient relationship.

The Judicial Council of The Medical Society of New Jersey concurs in the sentiments expressed by the AMA Judicial Council in 1962:

Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable.

The Judicial Council offers the following statement of the AMA Judicial Council (November 1968) as relevant:

In referring any account to a collection agency, the physician should first give due consideration to the patient's ability to pay the fee which is due. Secondly, the physician should not utilize the services of a collection agency whose tactics and methods of collection might bring the medical profession into disrepute. The physician may not "sell" his delinquent accounts to a collection agency and may not enter into any arrange-

ment under which the physician would lose complete control of the delinquent account or the method of its collection.

For the aforementioned reasons, the Judicial Council of The Medical Society of New Jersey is of the opinion that the questioned practice is not ethically acceptable.

Considering a proposal of a national specialty society to issue advisory dicta for its members, the AMA Judicial Council has recently stated (September 1971):

"... it (the Judicial Council) must emphasize the fact that the preamble and the ten sections of the Principles of Medical Ethics are an ethical code for *all* physicians. It assumes what you are seeking to draw up is a set of policy positions to assist your members in applying the Principles of Medical Ethics to the particular circumstances of your specialty. It is necessary and adequate to have one code of ethics for all physicians. Separate codes for specialty groups or societies of physicians would fragment and dilute the effectiveness of general ethical guidelines and ultimately cause chaos. Specialty societies may quite properly establish policy positions or guidelines consistent with those general ethical principles to aid their own members in applying the Principles in situations peculiar to their specialty."

The Judicial Council of The Medical Society of New Jersey points out that the statement which it disapproves cannot be excused as attempting to establish positions or guidelines consistent with the accepted and applicable general ethical principles. "How a doctor handles his private billing" is not exclusively a "personal matter." Section 1 of the "Principles of Medical Ethics" asserts:

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 4 of the "Principles" adds a further relevant mandate in the sentence: "Physicians should observe all laws, uphold the dignity of the profession and accept its self-imposed disciplines."

The patient is a human being whose rights as such must be protected; his confidences as such must not be violated. The physician is required to uphold the honor and dignity of the profession. How and under what circumstances a physician bills may reflect adversely on the entire profession. This cannot be tolerated.

For all the foregoing reasons, the Judicial Council of The Medical Society of New Jersey disapproves the subject statement of the Judicial Ethics Committee of the New Jersey State Society of Anesthesiologists, Inc. as incompatible with the official ethical principles and dicta of the American Medical Association and of The Medical Society of New Jersey.

By unanimous action the Council adopted the foregoing opinion and directed that it be transmitted to the New Jersey State Society of Anesthesiologists, Inc. and to the Judicial Committees of all the component societies of The Medical Society of New Jersey.

#### GUIDELINES FOR APPEAL HEARINGS

From the minutes of the meeting of 27 June 1971, the Judicial Council presents the following report of action taken adopting guidelines governing the granting or rejection of requests for appeal hearings.

In cases wherein a careful review of the record indicates that a Judicial Committee in the course of a hearing has been presented with testimony and/or other evidence concerning all relevant and material facts necessary to make a determination, the Judicial Council will, in its discretion, deny a request for an appeal hearing which is based solely on factual issues. The Judicial Committee is in the best position to collect and evaluate the full facts, and having done so, an appeal hearing to re-evaluate those facts would serve no useful purpose.

Of late the Judicial Council has had a number of inquiries concerning the ethical acceptability of a physician's entering upon employment with a commercial enterprise that advertise certain services—such as hair transplants—to the general public, and in such advertisements include such statements as “all services are rendered by licensed physicians” or “all work performed by professional licensed personnel.” The Judicial Council in all such inquiries offers the following official statement of the AMA Judicial Council as relevant and controlling:

It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures out-

side the practice of medicine. However, out of respect for his profession he should not allow his name or the *prestige of his professional status as a physician* to be used in the promotion of commercial enterprises. (*italics supplied*)

#### ADHERENCE TO REGULATIONS

The Council points out to the chairmen of the judicial committees of the component societies that there continues to be some inadequacy of cooperation with the Judicial Council on the part of the committees. One of the main problems is failure to file, or lateness in filing, the required report forms to inform the Council of the existence and status of complaints before county judicial committees. Many times the Council has received requests for appeal hearings concerning complaints disposed of, but not reported, by county judicial committees.

In other instances, investigation has disclosed that some county judicial committees disregard the requirement that all principals be invited to be present and to participate in the hearings that are mandated whenever an amicable settlement proves impossible of accomplishment.

The Council urges that each county judicial committee strive to improve its procedures in these regards. Therefore, the committees are again reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints*. Only by means of a full understanding and observance of the “Regulations” can the judicial committees together with the Judicial Council succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

Approved (page Tr 127)



## Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")

Once again the time is here for the filing of income tax returns and the compiling of annual reports. It is a revealing time of annual stock-taking, in the course of which we can discover our situation and evaluate our profit or loss. One realization is inescapable for all of us, as individuals and as workers in medicine: we are being borne along on a turbulent, surging stream of changeful life, toward uncertain ultimate destinations. Personal direction and control of our lives is a progressively diminishing phenomenon. The sole remaining area for individual action lies in the effort to temper and ameliorate the nature and extent of the changes which modified mores, restless societal demands, and governmental controls thrust upon us. In that vital effort we have been totally engaged throughout the administrative year now ending.

It is not surprising, therefore, that the volume of business before us as a society has been greater than ever—as the number and length of the meetings of the Board, the councils and the many committees, and the increasing bulk of minutes and correspondence clearly indicate. The compendious reports before the House—and they are only concise summaries—disclose how well and how thoroughly all our officers, members, and staff have cooperated in the endeavor to meet the challenges of the times and to get the job done. Law and legislation, medical education at undergraduate and graduate levels, the use of paramedical personnel, methods of improving the delivery of quality health care, peer review, medical foundations, mental health in its many ramifications, disaster medical care, environmental control, drug addiction control, intra- and inter-professional cooperation, professional liability insurance, national health insurance—all of these and a host of other subjects have been our constant concern. And apparently they will continue to be our concern in the days and years

ahead. Certainly in these times, "No man is an Island . . . each is part of the maine." That is why it is imperative that we work as one for the preservation of the integrity and strength of the profession and for the advancement of the true good of our nation and of our people.

The year was saddened by the deaths of three men who rendered long and outstanding service to The Medical Society of New Jersey: Jesse McCall, M.D., Frank B. Vanderbeek, M.D., and Jerome G. Kaufman, M.D. Living they inspired us by their high-souled dedication. May their spirits remain with us as models for our imitation.

Since my coming to this Society, I have been constantly impressed with the character and industry of all with whom I worked in the fulfillment of our shared duties and responsibilities. This year's experiences have been likewise rewarding. To the President, the Chairman of the Board, and all the other officers, to council and committee chairmen and members, to all the members of our gifted and diligent staff, I express my gratefulness and admiration for their unfailing goodwill and unstinting cooperation. The Medical Society of New Jersey should be proud of them all.

Most of my work keeps me at my desk and on the telephone. However my diary discloses that in the course of the year I participated in about 145 meetings and conferences of all kinds, visited 11 component societies, made 10 speech presentations, and took two trips out of State on Society business.

This year some innovations are being incorporated on an experimental basis in the schedule of the annual meeting, in the effort to make possible the attendance of delegates at more than one reference committee meet-

ing, and to make possible the final adjournment of the House at an earlier hour on the day of the close of the meeting. We hope that the changes in schedule will work out to the satisfaction of all and that members will make every effort to transact the official business of the House expeditiously.

It is not possible neatly to package the work of the year and to stamp it completed. The

business of this Society is dynamic and continuing, as is the professional life of every member. Our basic challenge is to do each day's and each year's stint of work as it presents itself. To meet that challenge we have all given our best and our utmost. We hope that our efforts merit the approbation of our members.

Approved (page Tr 127)

## Annual Meeting

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "H")

The Committee met in July to formulate plans for the 206th Annual Meeting in accordance with directives of the 1971 House of Delegates and of the Board of Trustees. Two joint meetings with the Committee, Officers of the Scientific Sections, and representatives of New Jersey Specialty Societies were held—one in July and one in September.

As a result of past experience, the Committee critically reviewed its efforts to determine ways and means of improving the over-all format of the Annual Meeting and has attempted this year to include those suggestions which it felt had merit.

The final meeting of the 1971-72 Board of Trustees will be held in Haddon Hall at 4:00 p.m., Friday afternoon, 5 May; and the reorganization meeting is scheduled for 8:00 p.m., Tuesday evening, 9 May.

In an attempt to devise a plan whereby more of the delegates will be free to attend more than one reference committee meeting, the schedule for the sessions of the 1972 House of Delegates will not follow the format of previous years. The first session of the House will be at 2:00 p.m., Saturday, 6 May, and official guests will be called upon to make brief

presentations at this session only. Also during the first session, the President of the College of Medicine and Dentistry of New Jersey, Dr. Stanley S. Bergen, Jr., will be called upon to receive the AMA-ERF checks.

The second (election) session of the House will be followed by the General Session and will feature the farewell message of the President and the inaugural address of the President-Elect.

The third session, Part I, will take place on Monday, 8 May to consider the reports of the reference committees that met on Saturday ("A", "B", "D", "G" and Constitution and Bylaws); Part II of the third session of the House will be held on Tuesday, 9 May to consider reports of the reference committees that met on Sunday ("C", "E", "F", and "H"). This change in format is being scheduled on a trial basis for one year.

The Nominating Committee will meet at 5:00 p.m., on Saturday; reference committees are scheduled for 3:00 p.m. on Saturday and 10:00 a.m. on Sunday. Reference committee reports will be made available in advance of distribution to the House to members of the reference committee and to *one* officially designated representative of each component society.

Registration will open in the Exhibit Hall at 10:00 a.m. on Saturday. Under the auspices of the Council on Public Relations, the 15th Golden Merit Award Ceremony will take place at 12:00 noon on Saturday, and will be followed by a reception for award recipients and their families.

The 1972 Scientific Sessions have been scheduled for Sunday and Monday during hours which will not conflict with sessions of the House of Delegates. The 1972 Motion Picture Theatre will again be sponsored by Roche Laboratories, Division of Hoffmann-LaRoche, Inc., and an outstanding selection of timely films will be shown on Saturday, Sunday, and Monday.

Each year the technical exhibitors are guests of the Society at a reception-buffet dinner. This affair is scheduled for Saturday evening and all delegates, members, guests and their wives are cordially invited to attend. Tickets will be on sale at the Registration Desk.

The Inaugural Reception is scheduled for Sunday evening. All registered members, official guests, and their wives are invited to attend; admission will be by badge. The Annual Dinner-Dance, honoring the President, will be held on Monday evening.

This year there will be three Alumni Receptions given by the College of Medicine and Dentistry of New Jersey, Hahnemann Medical College, and Jefferson Medical College. These three receptions are scheduled for 5:30 p.m. Monday, preceding the Annual Dinner-Dance.

The advance program was mailed early in February to the membership, invited speakers and guests, non-member exhibitors, and editors of journals of nearby state medical societies. The April issue of *The Journal* carried program revisions that were made since the printing of the advance program, as well as the detailed day-by-day outline of the annual meeting, and abstracts of the scientific session presentations. The final program will be distributed to all who register at the convention.

In an effort to draw attention to the annual meeting, the Committee was responsible for the postage meter advertisement which has been carried on all correspondence leaving the Executive Offices since last September.

Twenty-nine scientific, 14 informational, and 35 technical exhibits will be presented. The Committee is grateful to the Prudential Insurance Company for their continued cooperation in sponsoring the Coffee Lounge, and to the American Association of Medical Assistants, State of New Jersey, for again assuming responsibility for the Message Center. All exhibits, the Coffee Lounge, and the Message Center will be located in the Exhibit Hall, Lobby Floor, Haddon Hall. All members and invited guests are urgently requested to visit the exhibits; admission to the Exhibit Hall will be by badge.

The Committee fully appreciates the increase in expenses and has made every effort to stay within the budget and yet arrange for an exceptional annual meeting. Again this year, in an effort to offset the loss of revenue caused by the reduction in the number of technical exhibits, the Board approved a recommendation that, in lieu of presenting exhibits, pharmaceutical houses, book publishers, etc., be invited to contribute to the Educational Fund of MSNJ. We are grateful to the following for their generous contributions: Eaton Laboratories, Division of the Norwich Pharmacal Company, Geigy Pharmaceuticals, Johnson & Johnson, Knoll Pharmaceutical Company, A. H. Robbins Company, Schering Corporation, and The Upjohn Company. Again this year, in accordance with a recommendation of the Board, a minimum charge of \$150 per ten feet of booth space will be levied on informational exhibitors.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

- 207th annual meeting  
—Saturday-Tuesday, 12-15 May 1973
- 208th annual meeting  
—Saturday-Tuesday, 11-14 May 1974
- 209th annual meeting  
—Saturday-Tuesday, 10-13 May 1975



## Recommendation

That the 210th annual meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Tuesday, 8-11 May 1976.

Approved (page Tr 141)

Report Approved with commendation (page Tr 141)

The Reference Committee recommended that the format used this year for Reference Committee meetings be followed next year.

## SCIENTIFIC EXHIBITS

Arthur Bernstein, M.D., Chairman

This year, in lieu of scheduling a fall meeting of the Committee in Trenton, the members were supplied with copies of materials pertinent to the 1972 Scientific and Informational Exhibits—applications, rules and regulations governing exhibits, invitation lists, etc.—and requested to send their suggestions to the Executive Offices. The Committee agreed that the 1972 Scientific Exhibit mailing list should include: Medical Directors of New Jersey, New York City, and Philadelphia hospitals; Deans of New Jersey, Maryland, New York City, and Philadelphia medical schools; Scientific Section speakers; New Jersey State Departments of Health and of Institutions and Agencies; and MSNJ Committee Chairmen. Letters were also directed to editors of journals of nearby states requesting that they carry items in their publications calling attention to our meeting, and inviting interested members of their societies to submit applications for space in the Scientific Exhibits.

The \$150 charge per ten feet of booth space will again hold for Informational Exhibits, with the exception of Committees of MSNJ.

Prior to the mailing of application forms, individual letters were sent to Presidents of Component Societies requesting their cooperation in stimulating interest on the part of their members and their area hospitals in presenting scientific exhibits that would be of interest to the over-all membership of MSNJ. Response to this request was most gratifying, and it should be noted that in 1972 there will be 13 Scientific Exhibits and 8 Informational

Exhibits presented in cooperation with hospitals.

The *Membership Newsletter* carried items calling attention to and urging participation in the Scientific Exhibits; and *The Journal* included a copy of the application form and regulations governing Scientific Exhibits in the November and December issues.

The Committee met formally in January, reviewed all applications on hand and assigned booth space. As of this writing, there will be shown 29 Scientific Exhibits and 14 Informational Exhibits. A listing of those applications received prior to printing was included in the advance program; and a complete listing, together with descriptive write-ups of all Scientific and Informational Exhibits will be carried in the April issue of *The Journal*.

A Committee on Awards was appointed to judge the Scientific Exhibits and to award plaques and certificates on the following basis:

- (1) First and second place award plaques for New Jersey exhibitors;
- (2) First and second place award plaques for out-of-state exhibitors;
- (3) Special Award Plaque from the members of the Committee on Scientific Exhibits to a New Jersey exhibitor;
- (4) Certificates of Merit to be presented to students from each of New Jersey's two medical schools;
- (5) Honorable Mention Certificates to be presented to New Jersey and out-of-state exhibitors (number of certificates to be determined on the basis of merit.)

The Committee has requested that announcement of the awards be made at the second session of the House of Delegates on Sunday afternoon, 7 May 1972.

Roche Laboratories, Division of Hoffmann-LaRoche, Inc., will again sponsor the Motion Picture Theatre. Four outstanding, timely films have been selected for showing on the mornings of Sunday and Monday, 7 and 8 May; and on the afternoons of Saturday, Sunday and Monday, 6, 7 and 8 May 1972.

Approved with commendation (page Tr 141)

The Reference Committee suggested that in order to stimulate presentation of more scientific exhibits by students in New Jersey medical schools, MSNJ award cash prizes for the two most outstanding such exhibits, and that the Committee on Scientific Exhibits be responsible for choosing the winning exhibits.

## SCIENTIFIC PROGRAM

James A. Rogers, M.D., Chairman

The Officers of the 1972 Scientific Sections met twice with the Committee on Annual Meeting, together with representatives of the New Jersey specialty societies.

The Committee was informed of a newly organized specialty society—New Jersey Chapter, American College of Emergency Physicians—and is pleased to announce that this group will cosponsor one of the scientific sessions at the 1972 annual meeting.

The Chairman of the Section on Psychiatry and Neurology suggested that that section be split into two separate sections—a Section on Psychiatry and a Section on Neurology and Neurosurgery. Prior to 1962, the section was titled the Section on Neuropsychiatry. On June 17, 1962, the Board approved a recommendation of the Committee on Annual Meeting "... that the name of that section be changed to 'Psychiatry and Neurology' in keeping with the terminology in use today. . . ."

The officers of the existing Section on Psychiatry and Neurology are also officers in the New Jersey Neuropsychiatric Association, and for the past several years the subject matter presented at the annual meetings by that section has been strictly psychiatric in nature.

Inasmuch as there exists today a New Jersey Neurosurgical Society, the Committee recommended—and the Board approved—that a Section on Neurology and Neurosurgery be formed, and that that Society be invited to cosponsor a program to be presented by the newly formed section at the 1973 annual meeting. The Section on Psychiatry has agreed to present a program in 1973.

The Committee is pleased to report that the invitation to New Jersey specialty societies to meet jointly with MSNJ's Scientific Sections has met with great success. This year, the majority of the specialty societies have arranged

their annual meetings and luncheons to coincide with our 206th Annual Meeting. The Committee feels that this is a tremendous step in bringing all of the members of MSNJ closer together.

All of MSNJ's Scientific Sections will meet in 1972, and your Committee takes particular pride in announcing that of the thirteen scientific sessions to be presented in 1972, eleven will be cosponsored by specialty groups. The following is the schedule for the 1972 Scientific Sessions:

*Sunday, 7 May 1972—a.m.*

Joint Session on Allergy, Otolaryngology, Pediatrics—to be cosponsored by New Jersey Allergy Society, New Jersey Academy of Ophthalmology and Otolaryngology and New Jersey Chapter, American Academy of Pediatrics

Joint Session on Medicine, Cardiovascular Diseases, Radiology—to be cosponsored by New Jersey Chapter, American College of Emergency Physicians, New Jersey Chapter, American College of Cardiology, New Jersey Society of Internal Medicine and New Jersey Chapter, American College of Physicians (*all-day meeting*)

Session on Ophthalmology—to be cosponsored by New Jersey Academy of Ophthalmology and Otolaryngology

*Sunday, 7 May 1972—p.m.*

Session on Anesthesiology—to be cosponsored by New Jersey State Society of Anesthesiologists

Session of Psychiatry and Neurology—to be cosponsored by New Jersey Neuropsychiatric Association and New Jersey Psychoanalytic Society

Session on Urology

*Monday, 8 May 1972—a.m.*

Joint Session on Chest Diseases, Clinical Pathology—to be cosponsored by New Jersey Society of Pathologists and New Jersey Chapter, American College of Chest Physicians

Joint Session on Dermatology, Plastic and Reconstructive Surgery—to be cosponsored by New Jersey Society of Plastic and Reconstructive Surgeons

Session on Obstetrics and Gynecology—to be cosponsored by New Jersey Obstetrical and Gynecological Society (*all-day meeting*)

Session on Orthopaedic Surgery—to be cosponsored by New Jersey Orthopaedic Society

Session on Surgery—to be cosponsored by New Jersey Chapter, American College of Surgeons, College of Medicine and Dentistry of New Jersey at Newark, Rutgers Medical School, New Brunswick and the Academy of Medicine of New Jersey (*all-day meeting*)

*Monday, 8 May 1972—p.m.*

Joint Session on Gastroenterology and Proctology, General Practice—to be cosponsored by New Jersey Academy of Family Physicians and New Jersey Proctologic Society

Session on Rheumatism

The following luncheons have been scheduled in conjunction with the Scientific Sessions:

New Jersey Chapter, American Academy of Pediatrics  
New Jersey Chapter, American College of Cardiology;  
New Jersey Society of Internal Medicine; and New  
Jersey Chapter, American College of Physicians  
New Jersey Academy of Ophthalmology and Otolaryn-  
gology  
New Jersey State Society of Anesthesiologists  
New Jersey Chapter, American College of Chest Physi-  
cians (Annual Selman Waksman Lecture)  
New Jersey Society of Plastic and Reconstructive Sur-  
geons  
New Jersey Obstetrical and Gynecological Society (Also  
25th Anniversary Dinner with speaker)  
New Jersey Orthopaedic Society  
New Jersey Chapter, American College of Surgeons;  
College of Medicine and Dentistry of New Jersey at

Newark and Rutgers Medical School, New Bruns-  
wick; and the Academy of Medicine of New Jersey  
New Jersey Society for Physical Medicine and Rehabili-  
tation

In addition, the New Jersey Committee on  
Trauma, American College of Surgeons, has  
scheduled its Annual Trauma Oration on Sat-  
urday, to be preceded by a luncheon; and the  
New Jersey Medical Women's Association,  
Inc. will hold a Brunch-meeting on Sunday.

A total of 65 eminent member- and guest-  
speakers will participate in the 1972 scientific  
programs.

Approved with notation (page Tr 141)

Credentials

Louis F. Albright, M.D., Chairman, Spring Lake  
(Reference Committee "A")

The Committee on Credentials throughout  
the year reviewed and acted upon member-  
ship applications and their supporting creden-  
tials as submitted through the component soci-  
eties.

The Committee extends appreciation to the  
secretaries of component societies, and to  
those who assist them, for their cooperation in  
processing membership applications. It would  
be especially helpful to the Credentials Com-

mittee of MSNJ if those who process creden-  
tials in the component societies would call  
specific attention to any deficiencies or ques-  
tionable data being submitted on the applica-  
tion form. This procedure will help insure  
more accurate and speedy evaluation of cre-  
dentials.

The following statistical breakdown reflects  
the committee's activities during the period 1  
April 1971 to 29 February 1972.

	Associate	Active by Advancement	Active	Total
Received . . . . .	364	264	77	705
Reviewed and found:				
Satisfactory . . . . .	329	239	62	630
Unsatisfactory . . . . .	0	0	0	0
Pending . . . . .	35	25	15	75
Total . . . . .	364	264	77	705

Approved (page Tr 127)

Honorary Membership

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg  
(Reference Committee "H")

No nominations were submitted this year to  
the Committee. Consequently, no meetings

were held during the administrative year.

Approved (page Tr 141)



# Finance and Budget

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal) year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

## THE JOURNAL AND ANNUAL MEETING EXPENSE

The anticipated *Journal* deficit has increased, for the third consecutive year. This can be attributed to several factors: (1) reduced volume of advertising supplied by SMJAB, while local advertising income has remained relatively stable; (2) the effects of the new rate structure reflecting 15% increase for full and for one-half page advertisements, although effective as existing contracts expire, will not achieve full impact on *Journal* income until 1 January 1973; and (3) the effect of a 9.3% production cost increase as of 1 March 1972. There was no increase for 1971 because of the price freeze. However, the trend set for 1972 is consistent within the printing industry, and it is felt that the printer has rendered another satisfactory year in printing *The Journal*.

Your Committee further noted that besides the *Journal* deficit each year, the Annual Meeting deficit has been charged to the unexpended budget balance and/or Unappropriated General Surplus.

In the past your Committee has recommended, with the concurrence of the Board of Trustees, the continuation of the Journal Deficit Reserve Account and the Annual Meeting Reserve Account established to offset any future deficits when there may not be sufficient unexpended surplus to absorb both deficits.

However, this year your Committee recommended, with the concurrence of the Board of Trustees, that the 1973 assessment include a \$3.50 and \$2.50 per capita assessment designated for each member's *Journal* subscription

rate and Annual Meeting registration rate, and that the Committee on Finance and Budget be called upon to review this designation annually.

Your Committee was cognizant of the fact that the above action will not completely discharge the deficits incurred each year in these two accounts. Nevertheless, the net deficit in each account will be far less and will readily be charged to the unexpended balance of the fiscal budget. Thus, your Committee recommended, with the concurrence of the Board of Trustees, that both the Journal Reserve and Annual Meeting Reserve Accounts be retired with the funds reverting to Unappropriated General Surplus as of 1 June 1972.

## MSNJ BUILDING LOAN

Your Committee has approved, with the concurrence of the Board of Trustees, the establishment of a new account to cover the long-term financing of construction costs (\$130,000) on the addition to the existing Executive Offices of The Medical Society of New Jersey. The initial payment of \$40,000 on construction costs will be paid from Unappropriated General Surplus with the remainder of \$90,000 drawn as a demand loan from the Medical Student Loan Fund at 5 per cent interest. The MSLF has \$145,000 invested in short-term, ninety-day renewal Certificates of Deposit yielding 5 per cent interest. The construction loan will be established allowing for interest and principal of \$45,000 to be repaid over the first five years and the remaining principal of \$45,000, with interest, to be paid over the next five years. The payments of interest and principal will be made prior to the end of each fiscal year, with your Committee given the authorization to adjust the rate of interest to that of the earning rate afforded other MSLF investments.

## 1973 ASSESSMENT

The computation of unappropriated cash surplus at the close of the current fiscal year is estimated at \$220,804.56—47.2 per cent above the \$150,000 sum which has been indicated as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is 1 January to 31 December, and the fiscal year is 1 June to 31 May. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It, therefore, becomes necessary to apportion the 1972 and 1973 per capita assessment to the 1972-73 fiscal year on the basis of 7/12 of the 1972 assessment for the new fiscal year soon to commence (1 June 1972) and 5/12 of the 1973 assessment for the latter part of that fiscal year starting 1 January 1973.

The following is the Computation of Cash Surplus and the Determination of the 1973 Assessment:

Proposed budget for 1972-73	\$488,738.00
7/12 of 1972 assessment applicable to 1972-73 budget	248,675.00
Amount to be raised by 5/12 of 1973 assessment	<u>\$240,063.00</u>
$\$81.38 \times 7,080$ members paid = \$576,170.40	
$\times 5/12$	<u>\$240,071.00</u>
Amount to be raised with surplus over \$150,000.00 applied to budget excess at 5/31/72, estimated	\$ 70,804.56
Amount needed to reduce the per capita assessment from \$81.38 to \$70.00	<u>33,563.00</u>
Remainder of surplus in excess of \$150,000.00	\$ 37,241.56
Add the required surplus	<u>150,000.00</u>
Estimated adjusted cash surplus at 5/31/72	<u>\$187,241.56</u>
$\$70.00 \times 7,080$ members paid = \$495,600.00	
$\times 5/12$	\$206,500.00
plus the amount raised from surplus	<u>33,563.00</u>
Amount to be raised to meet 5/12 requirement	<u>\$240,063.00</u>
For each \$1,000 increase in the proposed budget add 34¢ to assessment.	
For each \$1,000 decrease in the proposed budget subtract 34¢ from assessment.	

## 1972-73 BUDGET

The proposed budget for 1972-73 totals \$488,738. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

### Recommendations

1) That the budget for 1972-73 be adopted in the total sum of \$488,738.00.

Approved (page Tr 130)

2) That the 1973 assessment be adopted at \$70 per capital, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation, for the fourth consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor. Of the \$70 per capita assessment, \$3.50 and \$2.50 be designated respectively for the member's *Journal* subscription and Annual Meeting registration.

Approved (page Tr 130)

### FOOTNOTES FOR BUDGET

(1) Increase due to increments granted to both executive and general personnel. Except for one title and job reclassification, increments granted are in accordance with the 5.5% limit as set by the Pay Board — (Phase II).

(2) Increased to cover installation and monthly equipment charge on a new telephone system to accommodate the required changes in accordance with the expansion of the Executive Offices.

(3) Increased to cover travel expense to AMA Annual Convention, San Francisco, California.

(4) Increased to cover higher expenses anticipated on property tax, utilities, insurance, and interior repairs.

(5) Increased to cover higher salary taxes resulting from increased staff salaries.

(6) Increased to cover higher premiums on employee group insurance.

(7) Increased to cover the purchase of wall-to-wall commercial carpeting for the first and second floors of the expanded Executive Offices. Also, included are monies for needed conference tables and chairs.

(8) Establishment of a new account to accommodate financing of \$90,000 construction cost over ten years.

(9) Increased to cover the anticipated retainer fee for a Public Relations Counsel as approved (Board of Trustees) 27 February 1972.

(10) Increased to cover the cost of the Woman's Auxiliary President, President-Elect, and seven delegates to attend the AMA Convention, San Francisco, California.

(11) Increased to cover higher anticipated travel expense reimbursement in the furtherance of Continuing Medical Education in New Jersey.

(12) Increased to cover higher anticipated publication cost for the 1972-73 *Membership Directory*.

(13) Increased to cover higher anticipated expenses charged to this account.

ACCOUNT	CURRENT 1971-72 BUDGET	FOOT- NOTES	PROPOSED 1972-73 BUDGET
A- 1-Executive Salaries	\$ 75,693.00	(1)	\$ 82,132.00
A- 2-General Staff Salaries	124,960.76	(1)	135,759.81
A- 3-General Exec. Offices Expenses	18,000.00	(2)	21,000.00
A- 4-Executive Travel	3,300.00	(3)	3,950.00
A- 5-House Maintenance	19,600.00	(4)	25,600.00
A- 6-Treasurer	7,600.00		7,600.00
A- 7-Finance and Budget	75.00		75.00
A- 8-Secretary	400.00		400.00
A- 9-Salary Taxes	10,338.24	(5)	12,766.19
A-10-Insurance	10,600.00	(6)	11,055.00
A-11-House Reserve	8,000.00	(7)	15,600.00
A-12-MSNJ Pension Plan	1,500.00		1,600.00
A-13-MSNJ Building Loan	----	(8)	14,000.00
C- 2-Legislation	8,400.00		8,400.00
C- 3-Public Health	2,700.00		2,700.00
C- 4-Public Relations	7,200.00	(9)	9,400.00
C- 5-Medical Services	700.00		700.00
C- 6-Mental Health	1,600.00		1,600.00
D- 1-President-Presidential Officers	15,250.00	(3)	15,750.00
D- 2-AMA Delegates	15,110.00	(3)	16,600.00
D- 3-Woman's Auxiliary	3,660.00	(10)	6,650.00
D- 4-Medical Education	35,200.00	(11)	35,800.00
D- 5-Conference Groups	500.00		500.00
D- 6-Membership Directory	15,000.00	(12)	17,000.00
D- 7-Emergency Medical Care	300.00		300.00
D- 8-Credentials and Membership	700.00	(13)	900.00
D- 9-Archives and History	100.00		100.00
D-10-Project Hope-Vietnam	6,000.00		6,000.00
D-11-Medical Defense and Insurance	500.00		500.00
E- 1-Board of Trustees	6,700.00	(13)	7,000.00
E- 2-Contingent	10,000.00		10,000.00
E- 3-Judicial Council	500.00		500.00
E- 4-Legal	7,300.00		7,300.00
E- 6-Medical Student Loan Fund	6,000.00		6,000.00
E- 7-Authorized Reimbursement for Representatives to Meetings	3,500.00		3,500.00
TOTALS	<u>\$426,987.00</u>		<u>\$488,738.00</u>

Approved—The Reference Committee recommended that MSNJ re-evaluate its relationship to the Academy of Medicine relative to the contribution of funds to the Academy for 1973-1974 and thereafter. (page Tr 130)



# Medical Defense and Insurance

William J. D'Elia, M.D., Chairman, Neptune City

(Reference Committee "C")

## ACCIDENT AND HEALTH INSURANCE

The Society's accident and health insurance program is administered by E. & W. Blanksteen Agency, Inc. and has just completed its 42nd year of service to our members. This comprehensive disability income program affords a monthly benefit of up to \$2,200 during total disability due to injury or sickness. The program consists of two parts: the Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability the Basic plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65. Both the Basic-Extended plan and the Long Term plan are underwritten by the Nationwide Mutual Insurance Company. All of our Accident and Health policies now have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its Accident and Health Insurance programs for members of the Society, the company is committed to issue a guaranteed renewable policy for the same benefits as those provided each insured member under the Society's program.

### BASIC-EXTENDED PLAN

The Basic disability plan provides as much as \$1,200 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are payable from the first day of accident total disability for as long as five years and from the eighth day of sickness total disability for as long as two years. During 1971, waiting periods of 30 or 60 days were made available to provide reduced premiums for those whose circumstances make desirable a plan whose

benefits could begin on a later date than 1st day accident and 8th day sickness. The plan also provides, at half the monthly benefit rate, up to six months of accident partial disability benefits. The plan also includes accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime, and sickness total disability benefits may be extended for an additional five years, or a total of seven years altogether. There are 5,899 basic policies covering our members with some members having two basic policies. Extended coverage is included in 2,155 of these policies. Now that all our basic coverage is through one company, many members are combining two basic policies into one, when they are applying for an increase in their monthly benefit.

New members who apply for the basic-extended plan within their new member periods are issued coverage, within certain limits, without regard to medical history.

### LONG-TERM PROFESSIONAL INCOME PROTECTION PLAN

This plan, through the Nationwide Mutual Insurance Company, provides up to \$1,000 monthly benefit in addition to the benefits provided under the basic-extended plan. Benefits are payable to lifetime for accidental total disability, and to age 65 for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall in place, such as annuities, life insurance settlement options, and social security. The plan also affords six months of partial disability benefits at half the monthly benefit rate. Benefits may begin from the first day of accident or the eighth day of sickness or first day of hospitalization, whichever comes first; or from

the fifteenth day, thirty-first day, sixty-first day or ninety-first day of disability with appropriate reductions in premiums for the longer waiting periods. One thousand sixty-two members currently participate in this program which began in 1965.

It is possible for a member to have various disability plans and almost any combination of monthly benefits and plans to fit personal requirements. The ideal goal for most physicians is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax-free for federal income tax purposes.

The Committee, in 1971, arranged for a reduction in premiums for those under the age of 30 and for the Immediate and Fifteenth Day Plan in the 30 to 39 age category. It is expected that these improvements in the program will make it more attractive to the younger members of the Society and induce their increased participation.

#### MAJOR EXPENSE PLAN

Our Major Expense program was improved as of the March 1st 1972 anniversary date to keep pace with the increased cost of hospitalization and to provide more adequate coverage for our members.

The important changes in the program are as follows:

1. Maximum benefit for each accident of sickness has been increased from \$15,000 to \$25,000. (Claimants of Medicare age will continue to be covered by the \$7,500 maximum.)

2. The room and board daily rate has been set at \$100 for intensive care and \$50 for all other accommodations. (Previously, although there was no limit for a semi-private or ward accommodation, there has been a limit of \$30 a day for a private room. Research has shown that the vast majority of members and their families select private room accommodations, and therefore this constitutes, for most, a \$20 daily increase in a much-needed area.)

3. The private duty nursing benefit will now take into account \$24 for each eight hour shift. This could cover a maximum of \$72 for three shifts in one day. (Previously, there was a limit of \$37.50 of covered expenses for all nursing service for each calendar day. While this provided a higher payment for cases where nurses

were utilized for only one shift a day, it has worked a great hardship on those serious cases where two and three shifts of nurses have been requested for a long period of time.)

4. The deductible amount has been increased from \$500 to \$750. This will enable us to keep the premiums as low as possible. Furthermore, in terms of today's inflated costs of hospital, nursing, and other services, the \$750 deductible actually represents a lesser amount of such services now than the \$500 deductible did ten years ago. Medicare age participants' deductible has not changed. It remains \$750, or the Covered Expenses payable by Medicare—whichever is greater.

The program covers 2,743 members with many including coverage for their wives and children. New members to the Society may obtain coverage under the Major Expense Plan without regard to medical history provided they apply within their allotted two month new-member period. E. & W. Blanksteen agency, Inc. administers this plan.

#### HOSPITAL-MONEY PLAN

The Hospital-Money plan provides additional cash benefits when hospitalized for members, their spouses, and covered dependents. It can provide \$20, \$30 or \$40 a day for as many as 365 days for any one disability. At relatively low cost it provides benefits at the monthly rate of \$600, \$900, or \$1,200 while hospitalized.

In view of the very large costs that accrue when hospitalized, this program fills a real need for members since its benefits are not based on reimbursement for expenses incurred, but are in the form of a daily indemnity based solely on hospital stay. Three hundred seventy-eight members are presently covered under this program which is administered by E. & W. Blanksteen Agency, Inc.

#### LIFE INSURANCE—NATIONWIDE LIFE INSURANCE COMPANY

Last year, the maximum coverage under our Life Plan was increased to \$150,000—a 50 per cent increase over the \$100,000 maximum previously in effect. Our term life insurance program now includes not only the member but also his spouse, dependent children (be-

tween the ages 15 and 21, or up to age 26 if a college student) and employees. An important feature of this expansion is that each person will have his own five-year renewable and convertible term policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or employee. This added feature enables the life insurance program to serve many more needs of our members especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The life program provides each insured person a five-year renewable and convertible term policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program provides up to \$150,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children and employees. All coverage is issued in the form of convenient units of \$10,000 with waiver of premium and double indemnity for accidental death included without premium charge.

Last year \$195,000 in death benefits was paid out under this program bringing the total paid from inception to \$2,180,000. Through the large volume of insurance and strong participation of our members in this program, we are able to have non-cancellable term life insurance at a very low cost. At the present time our members are covered by \$27,920,000 of insurance currently in force.

#### SIX POINT HIGH LIMIT ACCIDENT INSURANCE PROGRAM

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company is administered by E. & W. Blanksteen Agency, Inc. and provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Special spouse coverage is available under this policy at very low cost. Seven hundred eighty-two of our members participate in this program.

#### PROFESSIONAL CORPORATION

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended/Long-Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Life Insurance Plan, and Six-Point High Limit Accident Insurance Plan, advises that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

#### Recommendation

That the E. & W. Blanksteen Agency, Inc., be continued as the official broker for MSNJ's Accident and Health, Major Expense, Hospital-Money, Disability, Life, and High-Limit Accident Programs.

Approved (page Tr 132)

#### PROFESSIONAL LIABILITY PROGRAM

The committee has been deeply involved in the professional liability area in order to assure continuation of our program and desirable modifications.

The dispute over the rates as proposed last year by the Employers Insurance of Wausau was included in our 1971 annual report. Discussions of its proposed rates continued during and beyond the 1971 convention. The company was unsuccessful in obtaining consent from the New Jersey Department of Insurance for a 48.5 per cent rate increase. As matters progressed it reduced its demand to 40 per cent in order to continue on the program and sought our support at this level. Based on information available to our committee, this increase did not appear warranted. After Employers Insurance refused to consider a reasonable increase, the committee determined that other insurance companies should be sought out to determine if they



were interested in our program and a long-term relationship.

Contact was made with several reputable and financially sound companies, and within a short time a written commitment was obtained from Chubb & Son Inc., which agreed to assume our *entire* program at a premium increase of 10 per cent above that charged the previous year. This increase reflected the effect of inflation on claim settlements and other rating factors.

Inasmuch as Employers of Wausau continued to maintain its strong posture regarding the need for a 40 per cent rate increase, it was decided that future coverage should be placed with a new insurance company. The official broker for the Society was notified and arrangements were completed to write policies for our members effective 1 September 1971, and thereafter through the Federal Insurance Company which is managed by Chubb & Son Inc. of New Jersey.

The new company is financially strong and has an excellent reputation for ability and integrity among legal circles and leading business and insurance organizations, including the New Jersey Department of Insurance. Our committee has been impressed with the manner in which the new company has responded to our program. We are particularly pleased to report that there will be *no rate increase* for professional liability premiums this year. This is the first time in more than ten (10) years that we are able to make this statement. Our professional liability program and the extensive participation in it by the Medical Society and its members have contributed to this pleasant change. However, we must recognize that this does not necessarily establish a pattern for the future. The same influences which have led to prior rate increases are still active, and conceivably future increases may be necessary if justified by acceptable statistics.

The changeover from one company to another is not without its complications. For in-

stance, Employers Insurance was providing information regarding existing and new claims. This permits periodic evaluation of losses, aids in determining future rates, and other pertinent information. (As an illustration of one study developed from this material, at the end of this report is a listing of the numbers of claims reported since 1968, by county and specialty.) It must be recognized that Employers Insurance will be involved in claims and suits for many years to come. It initially expressed reluctance to continue providing this data to our broker following termination of the program, but later reversed its position.

We have also encountered resistance with regard to Employer's previous commitment to use medical review and advisory committees and to abide by the decisions of these committees. It appears that the company prefers in many instances to rely on its evaluation of the merit of claims and suits. Since the original agreement has been terminated, we may not be able to force the company to live up to its previous commitment in this area without extensive legal action. Members of our Society were notified by the Committee that they could request hearings before medical review and advisory committees, prior to signing any authorization for settlement requested by the company.

Our program also includes the providing of personal catastrophe coverage, commonly called "Umbrella" insurance. This insurance is placed with the Employers-Commercial Union Insurance Company. In 1971 the policies were renewed with no increase in premium. There will be *no increase* in premiums for 1972 for this coverage.

The Committee also took action on the following items:

An insured physician who refused to sign the consent form for settling a professional liability claim, when a decision to settle had been reached by a majority of 75 per cent or more of those present at a medical review and advisory meeting, and where the defense did not prevail in a trial, could be denied renewal of his insurance, if the insurance company so decided for underwriting reasons.

Notified our members of the premium surcharge provisions of our professional liability program, including a new amendment which provides that any member who has six (6) or more nondefensible claims filed against him in a five (5) year period could be denied renewal of his insurance, if the insurance company so decided for underwriting reasons.

Opposed a request for establishment of an equitable fee schedule for reimbursement of members who serve on county medical review and advisory committees, since a provision of this nature would add to our costs and increasing rates.

Distributed information for benefit of our members regarding the provisions in the policy offered by Lloyds of London which are more limited than the coverage available under our policies; and also regarding the Professional Insurance Company of New York whose financial status in the past was a subject of concern.

Reaffirmed the position previously taken that coverage would not be provided for service corporations.

Representatives of the committee attended a two day public hearing in New York reviewing the problems of medical malpractice as they involve the consumer, insurance, legal, and medical fields. This was one of a number of public hearings held by a Federal Commission under direction of the Department of Health, Education, and Welfare. Additional studies are being conducted by advisory groups, which report directly to the commission. It is difficult to project what the commission will recommend in its report to be filed by 31 December 1972, and which element it will predominantly affect.

Recommendation

That the Joseph A. Britton Agency be continued as MSNJ's Official Broker for its Professional Liability coverage.

Approved (page Tr 132)

NUMBER OF CLAIMS BY COUNTY, IN EACH YEAR INDICATED

	No. Insured	1968	1969	1970	1971	Total
Atlantic	90	—	2	3	3	8
Bergen	724	3	24	41	71	139
Burlington	129	—	2	7	17	26
Camden	280	4	7	9	26	46
Cape May	16	—	—	1	—	1
Cumberland	56	—	—	3	13	16
Essex	1169	2	43	74	104	223
Gloucester	48	—	3	3	5	11
Hudson	459	1	16	25	36	78
Hunterdon	52	—	2	—	3	5
Mercer	246	—	12	9	25	46
Middlesex	356	—	16	33	48	97

Monmouth	290	1	11	17	42	71
Morris	311	1	19	23	32	75
Ocean	121	—	6	6	23	35
Passaic	482	1	16	31	44	92
Salem	7	—	—	—	1	1
Somerset	95	—	4	6	14	24
Sussex	51	—	3	—	3	6
Union	556	6	25	60	80	171
Warren	29	—	1	1	3	5
Totals	5566	19	212	352	593	1176

NUMBER OF CLAIMS BY SPECIALTY, IN EACH YEAR INDICATED

	No. Insured	1968	1969	1970	1971	Total
Gen. Pract.— No Surgery	813	3	19	20	39	81
Internal Medicine	729	—	9	25	51	85
Pediatrics	365	—	8	16	17	41
Psychiatry	205	—	5	7	8	20
Radiology	210	2	11	17	36	66
Pathology	143	—	—	4	8	12
Dermatology	102	—	4	4	9	17
Ins. Co. & Phar- maceutical Employees & Retired	27	—	1	—	—	1
Neurology	52	—	2	2	5	9
Allergy	44	—	—	2	—	2
Other—No Surgery	67	—	3	1	3	7
Gen. Pract.— Minor Surgery	498	2	11	18	35	66
Gen. Pract.— Major Surgery	245	1	7	15	23	46
General Surgery	464	—	15	41	64	120
Ob.—Gyn.	452	2	26	33	70	131
Anesthesiology	310	6	34	43	56	139
Orthopedics	238	1	30	44	81	156
Ophthalmology	241	—	6	7	15	28
Otolaryngology	142	2	6	13	15	36
Urology	75	—	3	11	21	35
Neurosurgery	47	—	5	17	12	34
Plastic Surgery	37	—	1	3	7	11
Thoracic Surgery	29	—	3	—	4	7
Proctology	16	—	—	2	2	4
Cardiovas. Surgery	15	—	—	1	3	4
Employed Nurses Technician	—	—	1	4	3	8
Partnership Corporation	—	—	2	2	6	10
Totals	5566	19	212	352	593	1176

Approved with commendation (page Tr 132)

# Medical Education

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "D")

During the past administrative year your Committee dealt with several diverse and controversial matters which should be of keen interest to all MSNJ members. The major issues that were considered are discussed below in detail.

## RESOLUTION #14 (1971)—DEVELOPMENT OF MORE FAMILY PHYSICIANS

The 1971 House of Delegates adopted Resolution #14, Development of More Family Physicians. The Board of Trustees referred that Resolution to this Committee.

The Chairman discussed the Resolution and its implementation with the deans of the two medical schools and with Dr. Bergen, President of the College of Medicine and Dentistry of New Jersey. We were assured that the College will cooperate in the fullest, although it was noted that the deadline to admit and graduate at least 200 students a year by 1975, although desirable, is obviously impracticable.

## RESOLUTION #19 (1971)—REDUCING DURATION OF M.D. CURRICULUM

The 1971 House of Delegates adopted Resolution #19, Reducing Duration of M.D. Curriculum. The Resolution was also referred to this Committee.

The Resolution was discussed with the appropriate officials of the medical schools and they are moving toward implementation. The Committee did point out, however, that in considering acceleration it felt that the preservation of essential content and quality must take precedence over durational reduction.

## FOREIGN MEDICAL GRADUATES

As you know, two laws became effective last year that circumvented the requirement of ECFMG certification for foreign medical graduates in New Jersey internship programs. Subsequently the Council on Medical Education and the Educational Council for Foreign Medical Graduates worked out a "Fifth Avenue of Approach" so that New Jersey hospitals and those in other states faced with similar legislation will not jeopardize the accreditation of their educational programs.

At this writing it is unclear whether the State Board of Medical Examiners has taken the steps necessary to implement this approach. We have been told that a number of our hospitals have been notified by the AMA Council on Medical Education that their internship programs are on probation. Hopefully, the State Board of Medical Examiners will resolve this situation shortly. This Committee stands ready and willing to assist in this endeavor.

## ENDORSEMENT OF SAMA PROJECT FOR MEDICAL EDUCATION AND COMMUNITY ORIENTATION (MECO)

This program seeks to place pre-clinical students in various community hospitals during the summer months to acquaint them with practical health care activities. Past experience has demonstrated that 80 per cent of the students involved expressed a desire to practice in the communities in which they served. The Committee is in accord with this concept and believes it worthwhile. At our request the Board of Trustees officially approved the establishment of the MECO Program in New Jersey, with the understanding that the neces-



sary legal details would be clarified between the Medical School and the State Board of Medical Examiners.

#### PEER REVIEW

While peer review consists of evaluation of the quality, quantity, and cost of patient care, the primary concern of the Committee on Medical Education is the quality of care. The Committee was pleased to learn of the establishment of the Statewide Committee on Peer Review. Hopefully, a working format for this most vital activity will be forthcoming in the near future.

Admittedly, peer review is a sensitive topic; however, it is an obligation which medicine has shouldered in the past and which must continue to be borne in the future. We believe the members of this Society are willing to meet the exigencies and to make the indicated changes.

#### AMA—ACCREDITATION OF PROGRAMS OF CONTINUING PHYSICIAN EDUCATION IN NEW JERSEY

The AMA has announced that it wishes state medical societies to assume the burden of accrediting continuing education programs on the statewide and local basis. Pursuant to communications received from the AMA Council on Medical Education, we formed a subcommittee to formulate a program to survey and accredit continuing medical education courses in New Jersey under the auspices of The Medical Society of New Jersey.

The Subcommittee has done a detailed study and issued a preliminary report in December. We are hopeful that its final report and recommendations will be available for a supplemental report to the 1972 House of Delegates.

#### CONTINUING EDUCATION FOR PHYSICIANS

There is a recognizable and growing trend across the nation to make participation in the

AMA Recognition Award Program a condition precedent to continued active membership. State medical societies such as Florida, Arizona, California, Kansas, Missouri, New Mexico, Oregon, and Pennsylvania have already effected the appropriate Constitution and Bylaw changes. In addition, the New Mexico Society supported legislation that required participation for future licensure.

Actually the fulfillment of the requirements in the AMA Recognition Award Program are not as difficult as most physicians assume. Most of us are already complying through staff meetings, grand rounds, lectures, specialty society meetings, and attendance at symposia. Therefore, little additional time, if any at all, would be needed to qualify.

In December 1971, we recommended to the Board of Trustees that continued MSNJ membership be contingent upon qualification for the AMA Recognition Award Program. The Board tabled the recommendation, but it is our hope that the Board will propose, without recommendation or prejudice, a resolution on that topic to the 1972 House of Delegates.

Approved (page Tr 133)

## Supplemental Report

#### ACCREDITATION OF CONTINUING MEDICAL EDUCATION PROGRAMS

The Committee on Medical Education has been working on a program that would place the duty of accreditation of state and local physician education courses on The Medical Society of New Jersey. The Council on Medical Education of the AMA has announced that subsequent to August 1972 it will no longer accredit continuing education programs of a state or local nature. Your Committee has gone into this matter in great detail and is prepared to undertake that responsibility on

behalf of The Medical Society of New Jersey and in accord with AMA guidelines. The following are offered with the concurrence of the Board of Trustees.

### Recommendations

(a) That the Committee on Medical Education be authorized to assume the duty of accrediting courses of continuing physician education in New Jersey in accordance with AMA guidelines and principles.

**Approved (page Tr 133)**

(b) That the Committee on Medical Education be authorized to negotiate approval of MSNJ's accreditation plan with the AMA Council on Medical Education.

**Approved (page Tr 133)**

### PHYSICIAN PARTICIPATION IN CONTINUING MEDICAL EDUCATION

The Committee has recommended to the Board of Trustees that participation in programs of continuing medical education totaling 150 hours in a given three-year period be made a requirement for continued active membership in the Society. The Board of Trustees at its 16 April meeting concurred in our recommendation.

The Committee would like to emphasize that many state medical societies have already made participation in the AMA Recognition Award Program a condition for continued membership. Some states have even made it a condition for relicensure. Most physicians

qualify unknowingly through their participation in departmental meetings, teaching, writing of articles, etc., and it will only be necessary for them to document their activities.

Since the trends are obvious, the Committee urges the House to carefully consider these elements and to adopt the following:

### Recommendation

That in order to continue active membership in MSNJ, members must participate in approved programs of continuing education for a total of 150 hours in a given three-year period, in accordance with AMA guidelines. (A program accredited by either the AMA Council on Medical Education or MSNJ's Committee on Medical Education is acceptable.)

**Approved (page Tr 133)**

Supervision of the foregoing will be the responsibility of the Standing Committee on Medical Education. Exceptions from conformity with the stipulated requirements may be granted to individual physicians for good cause shown to, and approved by, the Committee on Medical Education.

It should be noted that approval of this recommendation by the House will necessitate a change of Bylaws and therefore effectuation of the proposal cannot be expected until the 1973-1974 administrative year.

**Approved (page Tr 133)**



Speakers' Platform—Opening Session, House of Delegates.

# Medical Student Loan Fund

William Greifinger, M.D., Chairman, Essex

(Reference Committee "B")

In its fifteen years of operation, the Medical Student Loan Fund has granted loans totaling \$294,244.35 including \$444.35 as insurance payments, bringing the net loans granted to \$293,800.

To date the Fund has issued 274 loans to 162 New Jersey medical students. Seventy-one loans have been repaid in full. Twenty-nine borrowers are presently making quarterly repayments on an annual basis.

Requests for financial assistance by New Jersey medical students have remained constant during the 1971-72 administrative year. It is expected that this trend will continue for some time. Out of a total of eighteen students' requests, eleven were granted loans of \$1,500 and one for \$1,000, for a total of \$17,500.

It is estimated that the Fund will have \$41,000 available for loans for the 1972-73 school year. Of this amount \$4,500 is committed to prior applicants, leaving \$36,500 for new student requests. Applications and inquiries received to date from qualified medical students total \$19,500.

This report does not reflect the additional applications expected from other qualified medical students and your Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel the necessity to increase the \$1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest-free basis.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends and thanks Mr. Lambert and Mr. Squireck for their consistently efficient administrative assistance.

## PRESENT LOCATION OF RECIPIENTS OF LOANS

The 97 graduates are located as follows:

Interns—7 in New Jersey and 8 out-of-state	15
Residents—19 in New Jersey and 8 out-of-state	27
Armed Service—14 Army of the United States and 6 United States Navy	20
Private Practice—3 California, 1 Colorado, 3 Connecticut, 3 District of Columbia, 1 Maryland, 1 Massachusetts, 17 New Jersey, 2 New York, 3 Pennsylvania and 1 Virginia	35

Students presently in medical school—

13 seniors and 3 juniors	16
Current student loans outstanding	113
Medical students paid in full (71 loans)	49
Total New Jersey Medical Students	162

## CONTRIBUTIONS

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of Contributors since the last report follows:

## GENERAL FUND

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; County Medical Societies: Burlington and Cumberland. County Woman's Auxiliaries: Bergen, Camden, Cape May, Cumberland, Essex, Mercer, Middlesex, Monmouth, Passaic, Salem, and Warren. Despina Athans, Dr. Nicholas A. Bertha, Dr. and Mrs. Walter Booth, Dr. and Mrs. Joseph P. Calderone, Dr. John F. Connolly, Linda Connolly, Dr. and Mrs. Robert Cornwell, Dr. and Mrs. David Eckstein, Dr. and Mrs. S. S. Ellenson, Dr. and Mrs. Paul Ferrary, Dr. and Mrs. Philip Fiscella, Dr. and Mrs. Leon Friedman, Dr. and Mrs. George Glenn, Dr. and Mrs. Sidney M. Grobman, Mrs. D. Leo Haggerty, Dr. and Mrs. Irving R. Hayman, Dr. and Mrs. John Ianacone, Dr. and Mrs. Joseph R. Jehl, Dr. and Mrs. John F. Kustrup, Dr. and Mrs. Samuel J. Lloyd, Dr. Nicholas E. Marchione, Mr. and Mrs. David Marshall, Dr. and Mrs. Luke A. Mulligan, Dr. and Mrs. Donald McLean, Dr. and Mrs. Richard N. Outwin, Mrs. Hugh Palmer, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Paul Rauschenbach, Dr. and Mrs.



Carl Records, Dr. and Mrs. John L. Spaldo, Mildred Tarchiani, Dr. and Mrs. Irving Weiss, Mrs. Humphrey D. Wolfe, Dr. and Mrs. Edward Wolfson.

#### IN MEMORY OF

Mary Bacon, M.D., Mrs. William Barelman, William Basile, Mrs. Francis Benny, George Homer Bloom, M.D., Flora Borg, Richard T. Buckley, M.D., Richard R. Chamberlain, M.D., Abraham G. Chmelnik, M.D., Anthony Clemente, R. John Cottone, M.D., Peter Curtis, Alfred M. Elwell, M.D., Sallie Feinstein, Silvius Ferrary, Joseph M. Fitzgerald, M.D., Harry Fleischacker, Andrew F. Franzoni, M.D., Elizabeth Hansen, Elizabeth Hilpert, Mrs. George S. Idell, Mrs. Joseph Keating, Simon Marshall, M.D., Mr. Roger McC. Merrifield, Jesse McCall, M.D., Mr. Donald McLean, Mr. Joseph Neiring, George C. Parell, M.D., D. Parmelee, M.D., Anthony Pino, M.D., Harvey Rinzler, M.D., Bart Rossi, M.D., Mrs. Lucia Rube, Mr. Harley A. Sackett, David Schlein, M.D., Mrs. Mabel Scott, Lucious S. Tarchiani, M.D., Mrs. Ray Thombs, Arthur S. Thurm, M.D., Mrs. Ida S. Timmins, Charles F. Voorhis, M.D., Mrs. Eleanor Vreeland, Frank S. White, M.D., Mr. Joseph D. Zambone.

#### IN HONOR OF

Mrs. Charles Gandek, Mrs. Isadore Lipkin, Mrs. Donald McLean, MSNJ's Board of Trustees; MSNJ's Woman's Auxiliary Executive Board.

#### Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1972-73 in support of the Medical Student Loan Fund. surance Company, is administered by E. & W.

Approved (page Tr 130)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 130)

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund its number one project next year.

Approved (page Tr 130)

Report Approved (page Tr 130)

#### DISTRIBUTION OF LOANS

County of Residence	Medical School	Students	Loans Granted	
			1957-71	1971-72 March 31, 1972
Atlantic	Hahnemann	3	\$ 3,000	
	N.J. Medical	1	1,000	
	Pittsburgh	1	2,000	
	Temple	1	1,000	
	Tufts	1	4,000	
Bergen	Boston	1	1,000	
	Creighton	1	1,000	
	Hahnemann	3	5,000	
	Jefferson	2	4,500	
	Lovola	1	1,500	\$ 1,500
	N.J. Medical	7	11,000	
	N.Y. Medical	2	2,500	
	St. Louis	2	3,000	
Burlington	Duke	1	4,000	
	Hahnemann	1	1,000	
	Jefferson	3	8,000	1,500
Camden	Jefferson	3	5,000	
	Michigan	1	2,000	
	N.J. Medical	2	2,700	
	Temple	5	7,500	
	Hahnemann	4	3,500	3,000
Cumberland	Jefferson	1	2,000	
Essex	Albany	1	4,000	
	Bern	1	2,000	
	Duke	1	2,000	
	Hahnemann	3	8,000	

County of Residence	Medical School	Students	Loans Granted	
			1957-71	1971-72 March 31, 1972
Essex	Howard	1	300	
	Jefferson	1	3,000	
	N.J. Medical	12	25,000	1,500
	N.Y. Medical	2	2,000	
	Stanford	1	3,000	
	St. Louis	1	500	
	Temple	1	1,000	
	Georgetown	1	1,000	
Gloucester	Hahnemann	1	1,000	
	Temple	1	2,000	
	U. of Virginia	1	1,000	
Hudson	Georgetown	1	1,000	
	George Washington	1	3,000	
	Harvard	1	1,000	
	Howard	1	400	
	N.J. Medical	19	27,650	1,000
	N.Y. Medical	1	1,000	
	Pittsburgh	1	3,000	
	St. Louis	1	2,000	
Mercer	Hahnemann	2	3,000	
	Howard	1	1,000	
	Johns Hopkins	1	1,000	
	Meharry	1	250	
	Mississippi	1	3,000	
	N.J. Medical	5	9,500	
	N.Y. Medical	1	1,500	
	U. of Penna.	1	1,000	
	St. Louis	1	700	
	U. of Louisville	1	4,500	
Middlesex	Georgetown	1	1,500	
	Hahnemann	1	4,000	
	Wisconsin	1	1,500	
Monmouth	Columbia	1	2,000	
	Duke	1	1,500	\$ 1,500
	Georgetown	1	1,000	
	Jefferson	2	4,500	1,500
	Marquette	2	3,500	
	N.J. Medical	3	10,000	
	N.Y. Medical	1	4,000	
	Loyola, Stritch	1	3,000	1,500
	Temple	1	2,000	
	Up-State N.Y.	1	1,000	
Morris	Dartmouth	1	1,000	
	Duke	1	1,000	
	Loyola, Stritch	1	1,500	
	N.J. Medical	1	3,000	
Passaic	Jefferson	1	3,000	
	N.Y. Medical	1	1,000	
	Wisconsin	2		3,000
Salem	Duke	1	1,500	
	Jefferson	1		1,500
Somerset	Georgetown	1	1,000	
	N.Y. Medical	1	2,000	
	Temple	1	3,000	
	Western Reserve	1	1,000	
Union	Florida	1	1,000	
	Hahnemann	1	1,000	
	Jefferson	1	1,500	
	N.J. Medical	11	17,800	
16 Counties	31 Medical Schools	162	\$276,300	\$ 17,500
Total loans granted 3/31/72 .....				\$293,800

## Publication

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")

For the last five years, all medical journals have been plagued by decreasing advertising. This is due to three factors. Advertising budgets of pharmaceutical companies have generally been cut, the FDA requires fuller disclosure of contraindications and side-effects, and general industry conditions have worsened. One fortunate effect of this has been that the ratio of text (meaning everything but advertising) continues to increase. Because of the decline in advertising there has been a fall-off in the total number of *Journal* pages in 1971 from 1308 to 1232. Text pages in 1971 were about the same as in 1970 (752 to 737).

*The Journal* continues to publish items of interest to our members at the direction of the Board of Trustees, the Officers, the Councils and Committees, and from the College of Medicine and Dentistry of New Jersey and the State Department of Health—as well as the scientific articles on diversified subjects to appeal to the varied interests of our readers. There has been a gratifying increase in the "Letters to the Journal" section, which is always an interesting part of any periodical.

In response to an inquiry from the Board of Trustees, the Committee devoted almost an entire meeting to consideration of the increasing *Journal* deficit. A review of charts, showing the number of pages printed, the distribution of *The Journal*, the income, the printing costs, other expenses, total expenses, and expenses over income for each month of publication (and cumulatively) for the last three fiscal years, revealed that the primary factors responsible are increased printing costs and relatively stable income.

Based on these considerations, the Committee recommended (and the Board of Trustees approved) a 15 per cent increase in advertising rates for full and half-pages, effective as exist-

ing contracts expire—this will not reflect a noticeable increase in income until after January 1973. The Board also (on recommendation of the Committee) approved an increase in the subscription rate of *The Journal* to \$7, with \$1 for a single copy. This will raise the subscription rate for members (included in the dues) to \$3.50.

Other possible means of effecting economy in *Journal* publication, such as charging the cost of publication of the Transactions of the House of Delegates to the Secretary's office and the cost of the April issue (Annual Meeting Program) to the Annual Meeting were considered impractical. *The Journal* is the primary vehicle of communication for the Society and, as such, properly includes the publication of the Transactions and the Annual Meeting program.

Requested increases from Hughes Printing Company for composition, presswork, and bindery operation were accepted by the Committee and approved by the Board. Our contract permits yearly price adjustments in accordance with current labor rates.

We still have the smallest staff for the size of our membership and the size of our book. Our *Journal* is at least as large as and in some cases larger than that of other state societies of comparable membership, whose journal staffs are composed of from three to seven full-time employees.

I must mention the efficient and nationally respected work of our editor, Dr. Henry A. Davidson. Special accolade goes also to Mr. Joseph Cookson whose value to this publication cannot be overstated. He goes over our printer's bills, line by line each month, and is a veritable financial watchdog for us. He spends many days meeting with the printers and has saved us from excessive charges. The



one full-time member of the staff is Mrs. Treptow, who handles the day-by-day management of *The Journal* in a smooth and efficient fashion. She functions as the editor's secretary, handles problems relating to billing and circulation. She acts as liaison with authors. She works with Mr. Cookson in integrating the advertising pages with the text pages. She works with the engraver in connection with

the preparation and placement of illustrations. She reads all proofs. She maintains the files of the editorial office. She is the primary screening point for all correspondence to the editor. She is doing a prodigious job.

For the rest, *The Journal* speaks for itself.

Approved (page Tr 131)

### ACTION TO LIMIT DEBATE

At its first session on Saturday, 6 May 1972, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject, except by express permission of the House; and that the time be limited to four minutes per speaker, subject to the same exception.

## Revision of Constitution and Bylaws

William R. Muir, M.D., Chairman, Mount Holly  
(Reference Committee on Constitution and Bylaws)

The Committee had several proposals before it and dealt with each in accordance with the Bylaws (Chapter IX, Section 17, b).

### PROPOSED AMENDMENT TO THE CONSTITUTION (APPOINTMENT OF VICE-SPEAKER)

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1971 Annual Meeting, recognizing that such amendment must be considered by the House of Delegates for final vote

in 1972. The procedure outlined in Article XII, B, 10 has been complied with.

This proposed revision requires adoption by a two-thirds vote of the members of the 1972 House of Delegates present and voting at the final session.

### Recommendation

That the following amendment to the Constitution be adopted:

Article V—House of Delegates  
Section 2—Speaker  
*Current Proposed*

Speaker

Speaker and Vice-Speaker

The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.

Same

*The President shall also have the power to appoint a Vice-Speaker of the House of Delegates at each annual meeting. The Vice-Speaker shall be a member of this Society, and his duty shall be to assist the Speaker in presiding at the sessions of the House of Delegates. He shall not have the power to appoint committees.*

Approved (page Tr 142)

PROPOSED AMENDMENT TO THE CONSTITUTION  
(AFFILIATE MEMBERSHIP)

The Committee on Medical Defense and Insurance has recommended and the Board of Trustees has proposed an amendment to the Constitution creating the category of "Affiliate Membership." In accordance with Article XII of the Constitution this matter is being presented to the House of Delegates for its acceptance of the first year. Acceptance of a majority of those members of the House of Delegates present and voting at the final session is required. The Committee recommends the following proposed amendment to Article IV, Sections 1 and 8 of the Constitution:

## Exhibit #1

Article IV—Organization of the Society  
Section 1—Composition  
*Current Proposed*

This Society shall be composed of Fellows, Officers, Delegates, members, and associate members of component societies in good standing and Emeritus Members. Honorary Members may be elected, but they shall not be members of the corporate body.

Same

*Affiliate Membership may be granted but recipients may neither vote nor hold office.*

Section 8—Affiliate Members

*Affiliate Members shall be physicians who have been active members for at least five consecutive years but who no longer practice or reside in New Jersey. Applications for Affiliate Membership shall be directed to the Standing Committee on Medical Defense and Insurance for consideration and action. Affiliate Members shall be eligible to continue all insurance coverages offered by the Society except those relating to professional liability. The dues for Affiliate Members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.*

Foregoing amended by Reference Committee by deleting "or reside" (line 6); inserting after the word "directed" (line 9) the phrase; "through the component medical society" and inserting (after line 11) the phrase; "of The Medical Society of New Jersey," to read:

Affiliate Members shall be physicians who have been active members for at least five consecutive years but who no longer practice in New Jersey. Applications for Affiliate Membership shall be directed through the component medical society to the Standing Committee on Medical Defense and Insurance of The Medical Society of New Jersey for consideration and action. Affiliate Members shall be eligible to continue all insurance coverages offered by the Society except those relating to professional liability. The dues for Affiliate Members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.

Approved as amended (page Tr 142)

## Woman's Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

At its July 1971 meeting, the Board of Trustees approved the proposed program of the Woman's Auxiliary for 1971-72 as submitted. Because the work of the Auxiliary was so well planned and so smoothly carried out there was no need for a formal meeting of this Committee during the course of the administrative year.

By invitation from Stanley Bergen, M.D., President of the College of Medicine and Dentistry of New Jersey, the members of the Woman's Auxiliary enjoyed a delicious luncheon and an informative and enlightening tour of the Rutgers and Newark campuses and the opportunity to visit with medical students.

This year the Auxiliary has stressed involve-

ment in community service by the following means:

- (1) Interest in schools to encourage rubella vaccination as a pre-requisite to enrollment in kindergarten.
- (2) Amblyopia programs (very successful in three counties).
- (3) Health Careers—By presenting a health career film to high school students to interest them in and inform them concerning para-medical careers.

Top priority has been given by the Woman's Auxiliary to the Medical Student Loan Fund of MSNJ and to the AMA-ERF. To celebrate the 50th anniversary of the Woman's Auxiliary of the AMA, the goal of \$10,000 was set by the WA to MSNJ. To date \$7,832.18 has been realized.

Approved with notation (page Tr 141)



Auxiliary President, Mrs. Donald McLean, reporting to House of Delegates.



Mrs. McLean accepting Fellowette's Pin from President Davis.



# *Administrative Council*

## Legislation

Henry J. Mineur, M.D., Chairman, Cranford

(Reference Committee "E")

The death of Jesse McCall on 14 January 1972 deprived the Council on Legislation of its long-time Chairman and most distinguished colleague and The Medical Society of New Jersey of one of its truly eminent and beloved members. His sudden passing was a source of profound personal sorrow to all who knew him. We mourn his loss.

The 1971 House of Delegates approved, in principle, Resolution #11 and referred it to the Council on Legislation "for such implementation as is appropriate." The resolution called for a review and re-evaluation of the Council's legislative procedures. An "Ad Hoc Subcommittee to Review Council's Systems and Procedures" was established. It reported its recommendations to the Council on Legislation on 10 February 1972, and to the Board of Trustees on 20 February.

Among the principal approved recommendations are the following:

(a) *Concerning the Keyman Legislative Contact System*—The Committee found itself in agreement that the plan of the keyman legislative contact system is good in concept and in outline, but it needs to be brought to greater efficiency of operation. To accomplish this it recommended that:

(1) Keymen should be appointed by the proper officers of each component society.

(2) Each keyman should be selected on the basis of his/her intimate acquaintance with and easy access to the legislator or legislators to whom he/she is assigned.

(3) If it is necessary in the interest of efficiency to assign a separate keyman for each Senator or Assemblyman, that should be done.

(4) Keymen should be appointed for two years (since each legislature is to be constituted for a two-year period), subject to earlier replacement only if the legislators to whom they are assigned leave their legislative posts or the relations between keymen and legislators become impaired.

(5) It is recommended that the President-Elect, at the time of keyman appointments, should serve as coordinator of keyman activities in his county for the two year term of the legislature, i.e., through his incumbencies as both President-Elect and President. As President-Elect he should, of course, act only with the advice and consent of the President.

(6) Emphasis should be strongly placed upon the importance of naming only those physicians as keymen who have the best entrance to legislators and who are willing to do their jobs promptly and fully.

(7) Letters setting forth the foregoing should be supplied to Presidents and Presidents-Elect of component societies when the call for the appointment of keymen is issued. That should be done as soon as the list of legislators for the next two years is complete.

(8) The operation of the Legislative Keyman Contact System should be an item for discussion on the agenda of each meeting of the Conference of Presidents and Presidents-Elect of Component Societies.

(b) *Concerning Methods of Communication with Keymen and Legislators*—It was agreed that the present system of issuing both Informational and Action Bulletins to keymen and legislators would be continued. It was further agreed that efforts should be made to improve the Action Bulletins in terms of conciseness and clarity.

It was also agreed that in conjunction with Action Bulletins, which call for contact with the legislator by the keyman, a report form should be included with the bulletin that is sent to the keymen, together with a postage-paid, self-addressed envelope. A 48-hour deadline should be stipulated for the return of the completed report form to the Executive Office.

It is recommended that consideration be given to the designation of either a physician-member of the Council on Legislation or some other person, such as Mr. Meara, to serve as Coordinator of Keyman Contacts. It would be the task of the Coordinator of Keyman Contacts to get in touch by telephone with all keymen who have not submitted their completed contact report forms by the end of the stipulated deadline.

(c) *Miscellaneous Recommendations:*

(1) That a sixth official position concerning legislation be added to the five already used by the Society—"CONDITIONAL APPROVAL, because . . ." (here the reasons should be given upon which the approval by the Society is conditioned).

(2) That because of the new lobbying law the two physician-members designated as legislative educational representatives of the Society no longer be asked to attend sessions of the legislature, but that Mr. Meara, as the Society's Legislative Consultant, be used for any necessary contacts by the Society with legislators in the course of the legislative sessions.

(3) That, for the same reason, all messages to the legislators should be issued over the name of either the President of MSNJ or the Chairman of the Council on Legislation rather than that of the Executive Director, who, as a paid employee, would be subject to consideration for registration under the lobbying law.

(4) That a Conference Committee should be formed consisting of selected members of the

Council on Legislation and the two former legislative educational representatives, whose duty it will be to make themselves available to discuss bills with their legislative sponsors or to attend committee hearings concerning bills of medical interest.

(5) That, in instances in which the Society seeks conference contact with legislators, Mr. Meara should be asked to arrange the time and place.

(6) That a special group of Society representatives, each of whom is *persona grata* to the Governor, should be designated by the President to meet with the Governor, by official arrangement from time to time in behalf of the Society's legislative interests.

(7) That specialty societies continue to be invited to send representatives to all meetings of the Council on Legislation and that Presidents-Elect or chairmen of legislative committees of component societies be also invited to attend.

(d) *Concerning Board Action on Positions Taken by the Council on Legislation*—The Committee recommended:

(1) That at each session of the Board of Trustees at which a report is to be presented from the Council on Legislation, either the Chairman or the Vice-Chairman of the Council attend to present the report and discuss its contents.

(2) That in the occasional instance in which the Board finds itself disposed not to approve a position as initially recommended by the Council that the Board adopt a position of "DEFERRED BY THE BOARD OF TRUSTEES, because . . ." and return the bill to the Council for reconsideration.

(3) That except in an emergency the Board make it a policy not to consider and act upon legislative measures that have not yet been before the Council on Legislation.

Of the bills reported to the House in 1971, the following were signed into law:

*APPROVED*: S-747, S-896, S-913, S-949, S-977, S-998, S-2091, S-2140, S-2184, A-496, A-1097, A-1211, A-1291, A-1386, A-2001, A-2055, A-2056, A-2181, A-2246, and A-2368.

*DISAPPROVED*:

S-2083—To permit licensing of graduates of foreign medicine in the United States after one year of internship in a hospital.

S-2088—This bill was reported to the House in 1971 (See July 1971 *Journal*—Transactions Issue—p. Tr 63). The Society originally disapproved the bill because, as first drawn, it concentrated excessive power in the hands of the Commissioner of Health over the operation and conduct of medical care facilities. Subsequently the bill was amended to overcome the Society's opposition and the objection of the Society was discontinued.

A-2131—To provide that no hospital which receives funds under the Medical Assistance and Health Services Act shall require as a condition to serving an internship an examination other than that required by the State Board of Medical Examiners.

*ACTIVE SUPPORT*:

A-2305—To prohibit podiatrists, doctors of medicine and surgery, chiropractors and psychologists from engaging in any form of advertising, whether as individuals or through professional service corporations.

*NO ACTION*: S-872

The following bills of medical interest were introduced into the Legislature in 1971, but too late to be reported to the 1971 House of Delegates:

S-2228—To establish the Aircraft Noise Control Act. *ACTION DEFERRED*, pending further information from the Department of Environmental Protection.

S-2260—To reorganize the Department of Institutions and Agencies, replacing the Board of Control with the Board of Institutional Trustees; provides for appointment of the Commissioner by the Governor and makes the Commissioner chief executive officer of the Department. *DISAPPROVED*, because this bill would retain mental institutions under the Department of Institutions and Agencies, and the Society supports establishment of a separate department of mental health headed by a licensed physician. LAW, C. 384 (1971).

S-2272—To amend the New Jersey Controlled Dangerous Substances Act. *APPROVED*, LAW, C. 367 (1971).

S-2275—To prescribe requirements to which all prescriptions for controlled dangerous substances must comply under supervision of the Com-

missioner of Health. *DISAPPROVED*, because (1) although we support all intelligent and practicable means of controlling drug abuse, the volume of drugs made available to addicts through doctors' prescriptions is minimal, (2) the work entailed in keeping these records would involve quite a bit of time and expense, and (3) because present New Jersey and Federal Legislation are adequate enough to control this type of drug abuse.

S-2280—To repeal Sections 1, 2, 3, 4 & 5 of Chapter 102, P.L. 1952 concerning the Prevention of Chronic Illness Act. *NO ACTION*

S-2295—To repeal P.L. 1952, Chapter 230, requiring registration of certain persons convicted of crimes or offenses relating to the use, possession, sale, transportation or other dealings with any narcotic drug. *APPROVED*, LAW, C. 231 (1971)

S-2303—To authorize the State Board of Higher Education to contract with and provide compensation to any school of medicine listed in the World Directory of Medical Schools which has an enrollment of not less than 150 students who had been residents of New Jersey for at least 12 months prior to entering medical school, to furnish training in medicine to such students; appropriates \$1,500,000. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES*, because the money would be better spent to enlarge and equip the present two schools and to establish a third medical school in the State of New Jersey.

SR-2015—To create a commission to study methods of relieving the existing difficulties of the several health care institutions of Hudson County to provide more efficient management and adequate funding of such institutions. *APPROVED*

A-2398—To create a guaranteed medical education loan program within the Higher Education Assistance Authority. *APPROVED*

A-2417—To establish the Clean Ocean Act to regulate and control the disposal of waste in the ocean off the coast of the State and to authorize the Commissioner of Environmental Protection to adopt rules and regulations. *APPROVED*, LAW, C. 177 (1971)

A-2431—To appropriate \$11,725,208 to the Department of Institutions and Agencies from the Public Buildings Construction Fund for construction at the Greystone Park Psychiatric Hospital. *APPROVED*, LAW, C. 262 (1971)

A-2451—To provide for admission to examination for a health officer license any applicant licensed to practice medicine in New Jersey. *APPROVED*, LAW, C. 454 (1971).

A-2452—To amend the Health Care Facilities Planning Act to permit consideration as public need, the needs of members of a religious body operating a health care facility. *NO ACTION*, LAW, C. 138 (1971)

A-2455—To amend the New Jersey Medical Assistance and Health Services Act to provide for a one



year contract, renewable annually, between the State and an underwriter and fiscal agent to administer payment of claims under the Act and to prescribe information on expenditures to be maintained by the underwriter and fiscal agent. *NO ACTION*

A-2476—To provide that bioanalytical laboratories shall bill clients directly and not through physicians as middlemen. *ACTION DEFERRED*, pending a conference with the sponsors of the bill.

A-2487—To permit boards of education to provide sex education in grades 7 through 12. *DISAPPROVED*, because sex programs should not be prohibited for pupils below the 7th grade, provided the programs and teachers are carefully screened and approved and parental approval is given.

A-2500—To provide for increased health manpower by giving the Board of Medical Examiners authority to develop and approve programs for training of syniatrists and to permit approved syniatrists to perform certain medical services under the supervision of licensed physicians or surgeons. *APPROVED*

A-2533—To appropriate \$10,000,000 to the Department of Education for drug education programs in elementary and secondary schools. *DISAPPROVED*, pending the findings and recommendations of *AR-2018*.

A-2537—To direct the Commissioner of the Department of Health to establish and operate a drug treatment center in conjunction with the Greater Paterson General Hospital, to be administered through the Division of Narcotic and Drug Control and to approve \$750,000 therefor. *APPROVED*

A-2545—To permit the Attorney General to establish a schedule of fees under the Legislative Activities Disclosure Act and to provide for monthly reports when legislature is in session to legislators and the Governor and his staff. *Introduced too late for Council Action*, LAW, C. 349 (1971).

A-2548—To provide that repeated and continued abuse, cruelty, neglect or abandonment by a parent causing a child to be without essential parental care such conduct may be construed and shall constitute a waiver of the requirement of written consent provided in Section 1 of P.L. 1954, Chapter 112. *Introduced too late for Council Action*.

A-2560—To provide that operators of a motor vehicle shall be deemed to have given consent to taking of samples of breath and urine to determine the presence of narcotic, hallucinogenic or habit producing drugs in the body. *Introduced too late for Council Action*.

A-2561—To provide penalties for operation of motor vehicles while under the influence of alcohol or drugs and to provide that presence of alcohol of less than 0.10 shall not give rise to presumption the defendant was or was not under the influence of liquor while in excess of that amount it will be so presumed. *Introduced too late for Council Action*.

A-2577—To provide the abortion to procure miscarriage of a pregnant woman is justifiable when committed upon a female with her consent by a duly licensed physician. *Introduced too late for Council Action*.

All other bills of medical interest that were not signed into law, vetoed, or withdrawn during the 1970-71 Legislative Session were filed in the State Library as of 11 March 1972.

## CURRENT STATE LEGISLATION

In the afternoon of 11 January 1972, the 195th (1972) session of the State Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members (24 Republicans, 16 Democrats) and the Assembly has a total of 80 members (39 Republicans, 40 Democrats and 1 Independent). By means of legislative bulletins the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, county society secretaries, and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Active Support .....	All-out support for the measure.
Active Opposition .....	All-out opposition for the measure.
Approval .....	Commended as satisfactory, but not actively supported.
Conditional Approval ..	To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.
Disapproval .....	Rejected as unsatisfactory, but not actively opposed.
No Action .....	Considered, but not regarded as significant or relevant to the proper interest of the Society.

All bills marked thus (\*) are identical with bills of last year—or preceding years—whose official positions were the same.

- S-3 —To provide that the advisory council on education of the handicapped children will consist of public and private professional and lay interests. *APPROVED*
- \*S-8 —To require boards of education to identify children between ages 3 and 5 years who require special education to prevent more debilitating handicaps and to permit establishment of suitable facilities, programs and special services including summer classes for such children. *APPROVED*
- \*S-9 —To create and establish a risk register for handicapped and high risk children in the Department of Health. *DISAPPROVED*, because it would be impractical of implementation because of its broad application and furthermore would lead to the necessary stigmatization of a potentially handicapped child and might also cause a great deal of undue anxiety in some parents.
- S-14 —To require local boards of health to notify persons bitten by an animal whether such animal is or is not affected by rabies within 12 hours after such determination. *APPROVED*
- \*S-42 —To permit application to the Board of Medical Examiners for exemption from licensing under the act concerning practice of medicine and surgery by persons holding an M.D. degree in the employ of a licensed hospital and performing services under direct supervision of licensed physicians. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.
- \*S-53 —To provide that any person who fails to clearly advertise or label poisonous or deleterious substances for household use without disclosing the generic names of ingredients shall be a disorderly person. *APPROVED*
- \*S-132 —To provide that it shall be a disorderly persons violation for anyone to abandon any disposable or reusable hypodermic needle or syringe without first destroying it. *DISAPPROVED*, because although the intent of the legislation is laudable, the measure imposes a disproportionate burden upon patients and physicians alike in the probably vain hope of limiting and measurably restricting the activities of illegal users of drugs.
- S-180 —To authorize a \$25,000,000 bond issue for establishment of education facilities for the multiple or severely handicapped children. *APPROVED*
- \*S-196 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten. *DISAPPROVED*, because under certain circumstances immunization against rubella is contraindicated.
- \*S-198 —To provide for the "Noise Control Act" and to empower the Department of Environmental Protection to promulgate codes and regulations and to appropriate \$100,000. *APPROVED*
- \*S-208 —To provide for the establishment of air pollution control commissions in the counties individually and jointly. *DISAPPROVED*, because there is no evidence that at the present time the control that is now exercised by the Department of Health is not satisfactory and that the personnel who would control these committees would be as well informed in the control of air pollution as the Department of Environmental Protection. Moreover, the prevailing unified control would be jeopardized.
- S-214 —To provide that any fresh meat sold at retail shall be wrapped in an entirely transparent container. *APPROVED*
- \*S-218 —To provide that no dog brought to a pound or shelter shall be sold or otherwise be made available for experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.
- \*S-233 —To provide that it shall be a high misdemeanor for any person to add any controlled dangerous substance defined in R.S. 24:21-2 to any food or beverage knowing that such may be consumed by other persons not knowing such food or beverage has been so adulterated. *APPROVED*
- \*S-238 —To provide for the establishment of a central registry of blood donors in the Department of Health and to appropriate \$50,000. *DISAPPROVED*, because it would be a duplication of record keeping by existing blood banks in the State of New Jersey with no appreciable advantages.
- \*S-242 —To authorize the Commissioner of Health to contract with voluntary, non-profit hospitals for early care, treatment, rehabilitation, counseling and education of drug users and their families and to appropriate \$150,000. *APPROVED*
- \*S-243 —To establish a Health Hazard Abatement Fund where municipalities may make application for State aid to defray expenses incurred in abating conditions harmful to the health and safety of occupants of buildings regulated by such municipalities. *NO ACTION*
- S-252 —To direct the Department of Health to establish a program for the care and treatment of persons suffering from terminal illnesses and to appropriate \$500,000. *APPROVED*
- S-253 —To direct the Department of Health to establish a program for the care and treatment of children suffering from terminal illnesses and to appropriate \$500,000. *APPROVED*
- \*S-263 —To include in the definition of optometry one who sells, at retail, to the general public spectacles or eyeglasses containing other than plane lenses; to provide that nothing in the definition of optometry shall prohibit a duly licensed ophthalmic dispenser from providing eyeglasses as prescribed by an optometrist or physician. *DISAPPROVED*, because the

- vending of such glasses is not proper or exclusive to the practice of optometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and is discriminatory.
- \*S-295 —To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*
- S-317 —To provide for the regulation of clinical laboratories and their personnel. *DISAPPROVED*, because (1) it is in conflict with, but fails to repeal the Bio-Analytical Laboratory and Laboratory Directors Act (C-45:9-42.1, *et seq.*); (2) it would permit specialists proficient only in narrow limits of clinical testing to direct laboratories and the work of others in areas they are incompetent to assess; (3) it would require licensing of all technical laboratory personnel, thus restricting recruiting, increasing costs, and disregarding the fact that the Report of the Bateman Commission urged *less* not more licensure; (4) it is discriminatory in that physicians in solo practice are exempt from its application but those in group practice are not; and (5) it imposes double licensure requirements on physicians who are pathologists—first they must be licensed by the Board of Medical Examiners as physicians and surgeons, and under S-317 they would have to be licensed again as laboratory directors.
- \*S-343 —To establish the Aircraft Noise Control Act. *ACTION DEFERRED*, pending further information from the Committee on Environmental Health.
- S-451 —To provide for the Local Health Service Act. *APPROVED*
- S-460 —To authorize the Commissioner of Health to purchase residential and non-residential care and treatment of drug addicts and abusers in non-State facilities. *APPROVED*
- S-464 —To require once a month fire drills in any private hospital, convalescent home, private mental hospital or private nursing home. *APPROVED*
- \*S-483 —To require all prescriptions for Schedule II substances to conform to requirements as defined in Section 6 of the New Jersey Controlled Dangerous Substances Act. *DISAPPROVED*, because (1) although we support all intelligent and practicable means of controlling drug abuse, the volume of drugs made available to addicts through doctors' prescriptions is minimal, (2) the work entailed in keeping these records would involve quite a bit of time and expense, and (3) because present New Jersey and Federal Legislation are adequate to control this type of drug abuse.
- S-508 —To require issuance and renewal of all professional and occupational licenses for a two year period and to provide for staggering expiration dates. *APPROVED*
- S-518 —To provide that the act concerning medical service corporations shall not apply to health maintenance organizations which deliver comprehensive health prevention, maintenance and treatment services. *NO ACTION*
- S-519 —To permit parole of persons sentenced for drug abuse and in need of treatment provided they obtain admittance to an appropriate treatment facility for in-patient or out-patient treatment. *APPROVED*
- S-544 —To transfer all functions, duties and powers exercised by the State Board of Control of the Department of Institutions and Agencies and the Nursing Home Administrator's Licensing Board to the Department of Health. *APPROVED*
- S-554 —To appropriate \$10,000,000 of State Lottery Fund proceeds for the establishment and maintenance of regional education centers for children with multiple or severe handicaps or both. *APPROVED*
- S-558 —To require all law enforcement officers to determine if any person found in an unconscious state is wearing an identification tag indicating he is an epileptic or diabetic. *APPROVED*
- S-566 —To provide that State requirement or standards concerning the processing, packaging, storage, distribution or sale of a food or food product for human or domestic animal consumption shall supersede provisions of any county, municipal or health district. *ACTION DEFERRED*, until copies of the bill are available.
- SCR-47 —To create a commission to study the operations of the pharmaceutical industry and to evaluate laws pertaining thereto. *ACCEPTED AS INFORMATIONAL*
- SJR-1 —To create a commission to study the nature, extent and amount of State aid programs for mentally retarded persons. *ACCEPTED AS INFORMATIONAL*
- SJR-7 —To create a commission to devise the most practicable way of establishing a judicial mechanism for dealing with drug addicts and others impaired by their psychological condition. *ACCEPTED AS INFORMATIONAL*
- SJR-8 —To create a council to formulate a program for dissemination of public information concerning drugs and drug abuse. *ACCEPTED AS INFORMATIONAL*
- A-10 —To repeal P.L. 1971, Chapter 231 thereby creating P.L. 1952, Chapter 230 requiring registration of narcotic addicts with the police. *NO ACTION*
- A-16 —To correct a typographical error in P.L. 1966, Chapter 141 concerning content of alcohol in a motor vehicle violation defendant's blood. *APPROVED*
- A-21 —To provide that State air pollution codes, rules and regulations may include, in addition to negative restrictions on the emission of pollutants, any affirmative requirements related thereto. *APPROVED*



- A-26 —To provide for examination of public school pupils suspected of being under the influence of controlled dangerous substances. *APPROVED*
- \*A-43 —To repeal the statute making attempted suicide a disorderly persons offense and to provide for hospitalization of such persons by a magistrate or judge of any court. *APPROVED*
- A-45 —To require freeholders in counties with facilities for detention of children under 16 years of age to establish tutorial and mental health programs under guidelines to be established by the Commissioner of Institutions and Agencies. *APPROVED*
- A-52 —To provide for exhaust emission standards which must be met in inspections of motor vehicles. *ACTION DEFERRED*, pending further information from the Committee on Environmental Health.
- \*A-57 —To prohibit use of lead paint on toys, furniture and interior of dwellings. *APPROVED*
- \*A-74 —To include persons who supply indispensable limited medical technical ancillary services under direction of regularly licensed physician under the immunity clause of the Medical Practice Act. *ACTIVE SUPPORT*
- A-78 —To create a Rutgers, South Jersey Medical and Dental College Planning Council. *DISAPPROVED*, because although the Society has consistently urged and strongly supported establishment of a third medical school in southern New Jersey as soon as possible, it approved and supported the incorporation of both existing schools—at Newark and Rutgers—under the title of "The College of Medicine and Dentistry of New Jersey" and under the control of one Board of Trustees. We hold that a third school should be under the same corporate title and the same Board's control.
- \*A-85 —To prohibit water pollution by thermal discharge except under approved conditions. *APPROVED*
- A-86 —To license and regulate the practice of collection agencies. *NO ACTION*
- A-98 —To make certain conduct by debt collectors a disorderly persons offense. *NO ACTION*
- \*A-121 —To permit freeholders in counties with no hospital for treatment of children with sickle cell anemia to appropriate not more than \$5,000 each for such diagnosis and treatment and not more than \$10,000 in first class counties with more than 800,000 population. *APPROVED*
- \*A-201 —To regulate the sales of medicine containing ethyl alcohol, antihistamines, dextromethorphan, phenobarbital or its salts, ephedrine or its salts or belladonna or any of its alkaloids. *APPROVED*
- \*A-204 —To appropriate \$1,000,000 to the Department of Health for family planning and related services. *NO ACTION*
- \*A-213 —To provide for origination of proceedings concerning child abuse. *DISAPPROVED*, because there is no dependable logical basis for the presumption that a parent or guardian convicted of "any crime or offense relating to the use, possession, sale, transportation or other dealing in or with narcotic drugs" would be per se guilty of child abuse. Furthermore, some of the individuals granted the right to initiate proceedings under this bill do not possess requisite educational and clinical experience to determine that the resultant injury was not accidental.
- \*A-237 —To prohibit the littering of waterways and adjacent shores and beaches and to regulate marine toilets and to repeal Chapter 13, P.L. 1954 and Chapter 170, P.L. 1958. *APPROVED*
- A-247 —To provide courses in public health in public schools shall include instruction in nutrition and selection and preparation of food for personal and family consumption. *APPROVED*
- A-255 —To provide for licensing of hearing aid dispensers by the State Board of Medical Examiners to create a Hearing Aid Dispenser Examining Committee and to provide for violations. *APPROVED*
- A-260 —To permit the Board of Medical Examiners to waive any requirements and conditions to be satisfied by applicants for license to practice medicine and surgery if it determines such action would beneficially serve the people of the State. *DISAPPROVED WITH ACTIVE OPPOSITION IF BILL MOVES*, as contrary to public interest, because it would in effect empower the State Board of Medical Examiners to set at naught the objective requirements of the Uniform Medical Practice Act regarding the granting of licenses to practice medicine and surgery in New Jersey, and permit them to grant licenses on the grounds of the purely personal and subjective judgments of Board members, who would be exposed unduly to pressures of all kinds.
- A-262 —To appropriate \$250,000 to the Department of Health for administration of the Renal Diseases Program. *APPROVED*
- A-269 —To increase membership on the State Board of Control of Institutions and Agencies from 9 to 11 members. *NO ACTION*
- \*A-285 —To provide that the act concerning licensing of physicians shall not apply to a physician or surgeon duly licensed to practice in any foreign country where requirements are not lower than in this State where such person is temporarily teaching in a medical school approved by the Board of Medical Examiners. *DISAPPROVED*, because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all

foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

- A-297 —To provide that any person, including a minor believing himself a narcotic addict, may be admitted to any State or county institution having special facilities for care and treatment of drug addicts. *APPROVED*
- A-303 —To require hearing and eye examination of every motor vehicle applicant and once every six years thereafter. *APPROVED*
- A-307 —To direct the acquisition of the Margaret Hague Maternity Hospital for \$1 for use of the College of Medicine and Dentistry. *ACTION DEFERRED*, pending reply from the Margaret Hague Maternity Hospital.
- \*A-315 —To authorize the Commissioner of Institutions and Agencies to establish a program for treatment of rehabilitation of drug addicts who are inmates of correctional institutions and to require freeholders to put such into effect in jails, workhouses, and penitentiaries of their counties. *NO ACTION*
- \*A-317 —To require motor vehicle license applicants to submit to eye examinations and once every four years thereafter. *DISAPPROVED*, because the Society has approved Assembly Bill No. 303 as a simpler and more practicable measure, particularly since it calls for re-examinations at six instead of four year intervals.
- \*A-329 —To require written consent of a parent of a pupil prior to administration to him by public school authorities of any drug or medication for experimental purposes or for stimulating the learning process. *APPROVED*
- \*A-342 —To permit medical assistance to foster children under the supervision of a private non-profit adoption agency. *APPROVED*
- \*A-350 —To provide that any applicant for a medical license in addition to supplying required proofs can show that he has been engaged in a reputable practice for 10 years shall be granted a license without further examination upon payment of a fee. *DISAPPROVED*, because it would abrogate the present discretionary powers of the Board to act on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof", "reputable practice", and "conceded eminence and authority in his profession."
- \*A-351 —To provide for granting an applicant a license to practice medicine and surgery upon proving that he was examined and licensed by the appropriate body of any foreign country. *DISAPPROVED*, because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all

foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

- A-356 —To permit a person related to one believed to be a narcotic addict to petition the court requesting such person be admitted to a hospital for treatment of his addiction. *APPROVED*
- A-359 —To require each district and regional board of education to appoint an advisory committee on narcotics for each high school in its district. *APPROVED*
- \*A-361 —To authorize the Board of Medical Examiners to grant employees of a municipal hospital who hold M.D. or D.O. degrees an exemption from the licensing requirements of the act concerning licensing of physicians. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.
- A-365 —To authorize the Department of Institutions and Agencies to purchase residential care and treatment for mental patients in existing non-State facilities. *APPROVED*
- \*A-394 —To provide for consent by minors to treatment for mental illness. *DISAPPROVED*, because the bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.
- \*A-398 —To prescribe that certain publications, listings, or communications shall not be deemed advertising by podiatrists, physicians, surgeons, chiropractors, and psychologists. *ACTIVE SUPPORT*
- \*A-402 —To provide for licensing, inspection and regulation of maternity homes and similar type facilities and to permit nursing home corporations to operate without requiring stockholders and directors to be residents of the State. *APPROVED*
- A-415 —To appropriate \$250,000 to the Department of Health for a chronic renal kidney disease program. *APPROVED*
- \*A-419 —To provide for eye examinations of every child enrolled in the kindergarten class and to permit boards of education to authorize examinations for pupils in other grade levels. *DISAPPROVED*, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.
- A-420 —To establish a program for hemophilia in the Department of Health. *APPROVED*
- A-423 —To direct the Board of Education to require immunization of all pupils against rubella



as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED*, because under certain circumstances immunization against rubella is contraindicated.

- A-427 —To permit boards of education to provide sex education for grades 7 through 12. *DISAPPROVED*, because sex programs should not be prohibited for pupils below the 7th grade, provided the programs and teachers are carefully screened and approved and parental approval is given.
- A-433 —To provide that the Commissioner of Environmental Protection shall formulate rules and regulations concerning the labeling and prohibiting, conditioning, and controlling the sale of cleaning agents whose use may tend to cause adverse effects on man or the environment. *ACTION DEFERRED*.
- A-446 —To eliminate the requirement for a post mortem examination where death occurs within 24 hours after admission to a hospital or institution. *ACTION DEFERRED*, until a copy of the bill is available.
- A-455 —To include any association created for the purpose of protecting animals under the act concerning the New Jersey Society for the Prevention of Cruelty to Animals. *DISAPPROVED* because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed—or is failing—to perform its responsibilities in enforcing those statutes.
- A-463 —To require all persons riding in the front seat of an automobile manufactured after 1 July 1966 to wear seat safety belts. *DISAPPROVED*, because there are certain medical conditions in which the wearing of seat belts is contraindicated.
- A-514 —To provide for the regulation of clinical laboratories in the New Jersey Clinical Laboratory Improvement Act. *ACTION DEFERRED*, pending further information from the New Jersey Society of Pathologists.
- A-523 —To require school buses to provide seat belts and protective padding for every seat. *APPROVED*
- A-539 —To provide under the Air Pollution Control Act that noise shall be considered an air contaminant and at a level greater than 108 perceived noise decibels shall be a prima facie evidence of air pollution. *ACTION DEFERRED*, pending further information from the Committee on Environmental Health.
- A-549 —To require labeling of frozen food that has been thawed. *APPROVED*
- A-571 —To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefor. *APPROVED*
- A-608 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension,

heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical investigation.

- ACR-3 —To create a commission to inquire into the condition of the nursing homes and the personal care facilities for the aged. *ACCEPTED AS INFORMATIONAL*
- ACR-28—To create a commission to study the use of, sources of and addiction to narcotic and hallucinogenic drugs in colleges, universities and high schools. *ACCEPTED AS INFORMATIONAL*
- ACR-31—To reconstitute the legislative commission to study the revision of child abuse laws. *ACCEPTED AS INFORMATIONAL*
- AJR-6 —To designate the week of March 5-11, 1972 as Nurse Education Week. *ACCEPTED AS INFORMATIONAL*

Approved with commendation and notation (page Tr 135)

## Supplemental Report

At its meeting on 16 April, the Board of Trustees considered and acted upon recommendations from the Council's meeting of 9 April. The Council therefore offers this Supplemental Report covering items dealt with since the compilation of its annual report.

### CURRENT STATE LEGISLATION

All measures thus marked (\*) are identical with bills of last year—or preceding years—whose official positions were the same.

- S-576 —To provide that no person, partnership or corporation shall sell any packaged foods in this State unless there is affixed thereto a label stating every ingredient in order of its predominance. *APPROVED*
- \*S-597 —To authorize the Commissioner of Health to provide for the care and treatment of drug addicts by public and private facilities, including out-patient care and rehabilitation treatment and to appropriate \$300,000. *APPROVED*
- \*S-605 —To provide that no person shall store or drain or dispose of dangerous or toxic chemicals in or on the soil unless the soil is protected by a dike or shield and unless an annual permit is obtained from the Commissioner of Environmental Protection. *APPROVED*



- \*S-606 —To create the New Jersey Medical Education Loan Fund in the Department of Higher Education. *APPROVED*
- \*S-607 —To authorize the Public Utilities Commission to regulate and control radioactive material, waste and by-product material and to provide for licensing and filing of annual reports. *DISAPPROVED*, because it is unnecessary and would conflict with the Department of Environmental Protection.
- \*S-613 —To create a guaranteed medical education loan program within the Higher Education Assistance Authority and to appropriate \$50,000. *APPROVED*
- S-622 —To grant any counselor, psychologist, nurse, or other staff member of a non-profit youth organization immunity from civil suit for damages in actions arising from efforts to help persons cure their dependency on or from the illegal use of controlled dangerous substances. *APPROVED*
- S-630 —To provide that no person shall operate a motor vehicle while in possession of a controlled dangerous substance. *APPROVED*
- S-631 —To provide that no person shall operate a motor vehicle while under the influence of a controlled dangerous substance. *APPROVED*
- S-639 —To transfer functions, powers and duties of professional boards to the Director of the Division of Consumer Affairs in the Department of Law and Public Safety. *DISAPPROVED*, because the personnel of the State Board of Medical Examiners are better qualified to pass upon the basis of suspending or revoking a physician's or surgeon's license, especially in arriving at determinations of physical and/or mental incapacitation or determinations concerning the standards of competent medical practices. The bill would place professional boards in the anomalous position of having the sole right to grant licenses which another agency has the sole right to suspend or revoke.
- S-640 —To provide that no renewal certificates of registration shall be issued by the Board of Pharmacy following approval of this act until the applicant submits satisfactory proof to the Board that he has participated in courses of continuing professional pharmaceutical education of the types and number of credits specified. *NO ACTION*
- S-661 —To define child care centers to include private and public child care centers, day nurseries, nursery schools, or other establishments of similar character; to define Local Child Development Council and to provide for a Child Development Committee in the Department of Education and other amendments. *APPROVED*.
- S-666 —To provide that any person who knowingly possesses or sells drug paraphernalia evincing an intent to use the same for unlawfully mixing, compounding or otherwise preparing any narcotic drug or unlawfully manufacturing, packaging or dispensing of any narcotic drug is a disorderly person. *APPROVED*
- S-686 —To grant physicians and surgeons immunity from liability for services rendered at the request of police where persons are suspected of operating a motor vehicle under the influence of liquor or drugs. *APPROVED*
- S-712 —To authorize the Commissioner of Environmental Protection to limit the treatment and disposal within this State of solid waste collected outside the State. *APPROVED*
- \*S-714 —To establish regional evaluation centers for mentally retarded, physically handicapped, handicapped, emotionally disturbed, socially maladjusted, and multiple handicapped children and to appropriate \$100,000. *APPROVED*
- S-728 —To reduce from 0.15% to 0.10% the weight of alcohol in the defendant's blood which shall not give rise to any presumption of drunken driving and to repeal Section 2 of C. 141, P.L. 1966. (See A-719) *APPROVED*
- S-739 —To prohibit an owner of a motor vehicle from permitting another person to operate such vehicle while impaired by the consumption of alcohol. *APPROVED*
- S-754 —To prohibit use of any decorations, draperies or curtains of highly flammable materials in buildings of a public character. *APPROVED*
- S-755 —To define and include toys under the act regulating sale, manufacture or distribution of highly flammable wearing apparel and fabrics. *APPROVED*
- S-773 —To require the Department of Environmental Protection to prepare periodic reports on ambient air quality in various regions of the State and to distribute such reports to news media for publication and to appropriate \$10,000. *APPROVED*
- S-774 —To authorize the Department of Environmental Protection to prepare design standards for marine toilets installed in boats operating in waters of this State and to provide that no vessel shall be provided a certificate of number under the Boat Act unless equipped with a marine toilet approved by the Department. *APPROVED*
- \*S-779 —To repeal R.S. 2A:134-4 which relates to the polluting of waters used for ice harvesting. *APPROVED*
- S-783 —To require persons who operate oil facilities to demonstrate to the Commissioner of Environmental Protection an ability to remove and contain any oil reasonably expected to be discharged from such facility under the Oil Pollution Prevention Act of 1971. *APPROVED*
- S-784 —To increase the membership of the Advisory Council on Solid Waste Management from 11 to 13 and to include thereon the Secretary of Agriculture and the Dean of the College of Agriculture and Environmental Science of Rutgers University. *APPROVED*
- \*S-789 —To provide that the implied warranties of merchantability and fitness under the Uni-

form Commercial Code shall not apply to contracts for sale of blood, blood plasma or human tissues or organs. *ACTIVE SUPPORT*

- S-791 —To provide that no person employed by any school district shall use the designation of doctor unless such degree is an earned or honorary degree conferred by a college or university acceptable to the State Board of Examiners for certification purposes. *APPROVED*
- S-817 —To establish a Department of Mental Health as a principal department of the State Government and to appropriate \$100,000 therefor. *APPROVED*
- S-830 —To increase membership on the State Board of Medical Examiners to 15 from 11, to provide the Governor power to appoint all members and to make all members full voting members. *APPROVED*
- S-835 —To provide a pilot program of mandatory civil commitment of certain drug dependent persons in treatment centers, to prescribe procedures and to appropriate \$1,500,000 therefor. *APPROVED*
- S-839 —To require the New Jersey Turnpike Authority to prepare an environmental impact statement on each project, addition or extension to the New Jersey Turnpike before final approval of such project. *APPROVED*
- S-841 —To create the New Jersey Health Care Facilities Financing Authority, define its powers and duties and to authorize the issuance of bonds and notes of the Authority. *APPROVED*
- A-307 —To direct the acquisition of the Margaret Hague Maternity Hospital for \$1 for use of the College of Medicine and Dentistry. (See A-767.) *DISAPPROVED*, because the college is primarily interested in education and should not become burdened with the administration and operation of state facilities not essential to that educational function.
- A-446 —To eliminate the requirement for a post mortem examination where death occurs within 24 hours after admission to a hospital or institution. *APPROVED*
- A-514 —To provide for the regulation of clinical laboratories in the New Jersey Clinical Laboratory Improvement Act. *ACTION DEFERRED*, pending a conference with the sponsor of the bill.
- A-646 —To provide for allocation of \$.005 for each 10 cigarettes or fraction thereof for research into causes, prevention and cure of diseases associated with cigarette smoking. *ACTION DEFERRED*, pending reply from the College of Medicine and Dentistry of New Jersey.
- A-647 —To increase the cigarette tax from 7 cents to 7.5 cents for each 10 cigarettes with the additional tax to be annually appropriated to the College of Medicine and Dentistry for research of causes, prevention, and cure of diseases associated with cigarette smoking. *ACTION DEFERRED*, pending reply from the College of Medicine and Dentistry of New Jersey.
- \*A-674 —To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to a licensed dentist who operates only x-ray equipment for dental radiographs and only under the direct supervision of a licensed dentist; to provide for 9 examiners, in place of 10, on the x-ray technician board. *APPROVED*
- A-699 —To provide that claims and reimbursement of physicians or psychologists shall not be denied for certain reasons under the act concerning group health insurance. *DISAPPROVED*, because the bill is unnecessary, since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.
- A-700 —To provide for reimbursement of licensed psychologists for eligible services under the act concerning medical service corporations. *DISAPPROVED*, because the bill is unnecessary, since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.
- A-701 —To provide for payment of services of psychologists under policies of health insurance provided by the act concerning the Life and Health Insurance Code whether the services are performed by a physician or a duly licensed psychologist. *DISAPPROVED*, because the bill is unnecessary, since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.
- A-719 —To provide that the presumption that a motor vehicle violation defendant was or was not under the influence of alcohol shall not arise where the alcohol content in a defendant's blood was in excess of .05% but less than 0.12%. (See S-728). *APPROVED*
- A-731 —To exclude storm doors from the act regulating safety glazing material. *DISAPPROVED*, because storm doors constitute a grave and frequent hazard, especially to children.
- \*A-740 —To require labeling of food where appropriate "This article of food was frozen and permitted to thaw" by the retail place of business. *APPROVED*
- A-757 —To provide that an act to cause miscarriage of the pregnant woman is justifiable when committed with her consent by a duly licensed physician acting within 24 weeks of the beginning of the pregnancy or under a reasonable belief such is necessary to preserve her life. *DISAPPROVED*, because the bill is not compatible with the official position of The Medical Society of New Jersey, which declares:
- ... Recognizing that there are many physicians who on moral or religious grounds oppose therapeutic abortion under any circumstances, The Medical Society of New Jersey is opposed to induced abortion except when:
- (1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or



- (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or
  - (3) There is documented medical evidence that continuance of a pregnancy resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient,
  - (4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing, and
  - (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals. . . . (Adopted 1968)
- A-767 —To authorize and direct the Board of Trustees of the College of Medicine and Dentistry to purchase for use the Jersey City Medical Center for \$1. (See A-307.) *DISAPPROVED*, because the College is primarily interested in education and should not be burdened with the administration and operation of state facilities not essential to that educational function.
- \*A-779 —To provide that the blind and otherwise physically disabled shall have the opportunity to public and private employment except where the disability prevents performance of work involved, and to obtain all public accommodations, publicly assisted housing and other real property without discrimination. *APPROVED*
- A-780 —To provide for packaging of meat in transparent packages and limited labeling on one side. *APPROVED*
- A-800 —To provide that firemen suffering disability or death from a respiratory disease shall be presumed to have been suffered in the performance of duty. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical evaluation.
- A-809 —To make the effective date of the act regulating the use of safety glazing material December 30, 1972. *DISAPPROVED*, because the protective advantages of the new law should accrue to the public at the earliest possible date.
- A-819 —To provide that the Board of Medical Examiners shall charge fees for licenses to practice medicine and surgery as provided for in the Statutes and where not so designated such fees shall be prescribed by rule or regulation. *ACTIVE OPPOSITION*, because the imposition of these fees, which are in excess of those applicable in other states, will tend to discourage young physicians from coming to New Jersey to practice.
- A-826 —To require the labeling of milk and milk products indicating the date beyond which the milk or milk product cannot be sold. *APPROVED*
- A-827 —To establish a New Jersey Ocean Sanctuary under the care and control of the Department of Environmental Protection. *APPROVED*
- A-832 —To permit freeholders in counties which have no county home or hospital for the diagnosis and care of children afflicted with Cooley's anemia to appropriate not more than \$5,000 each year for such care. *APPROVED*
- A-835 —To clarify certain sections of Noise Control Act of 1971 and eliminate veto power of the Noise Control Council. *NO ACTION*
- A-837 —To require school buses transporting school children to be equipped with emergency exits including roof exits with the standards to be prescribed by regulations of the State Board of Education. *APPROVED*
- A-838 —To provide that the rules and regulations of the State Board of Education for equipment on school buses shall include a requirement that the back of seats shall be 28 inches high and padded with energy absorbing load distribution materials and restraint systems for the drivers and passengers seats. *APPROVED*
- A-851 —To permit the sending of handicapped children to special classes in schools of any other State of the United States. *NO ACTION*
- A-862 —To authorize the Department of Health to establish a testing procedure for the detection of sickle cell anemia in children. *APPROVED*
- A-869 —To authorize counties to establish County Environmental Protection Councils. *DISAPPROVED*, because it unnecessarily duplicates the powers already vested in the State Department of Environmental Protection.
- A-870 —To provide for the regulation and registration of snowmobiles. *APPROVED*
- A-871 —Provides for rewards for persons furnishing information leading to the arrest and conviction of certain controlled dangerous substances offenders; appropriates \$100,000. *NO ACTION*
- A-875 —To authorize boards of education concurred in by the county superintendent to transport pupils to school where unduly hazardous traffic conditions exist. *APPROVED*
- A-882 —To require all vehicles transporting children to school to observe all traffic safety laws applicable to school buses. *APPROVED*
- A-904 —To permit qualified technical aides to perform limited medical procedures ordered by a responsible licensed physician. *CONDITIONAL APPROVAL*, providing that the bill is amended to indicate that the physician directing the technical aide shall certify as to his or her competence.
- A-908 —To amend the law concerning operation of a motor vehicle while under the influence of narcotics to conform to the New Jersey Controlled Dangerous Substances Act. *APPROVED*
- A-914 —To revise penalties for polluting fresh or tidal waters of the State to fines of not more



than \$2,500 for the first offense and \$10,000 for any subsequent offense. *APPROVED*

A-916 —To provide that disability or death of a policeman or fireman resulting from respiratory diseases shall be presumed to be job related. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical evaluation.

A-922 —To exempt certain non-prescription drugs from the sales tax. *NO ACTION*

A-925 —To provide that persons who illegally practice medicine or surgery shall be guilty of a misdemeanor. *APPROVED*

A-936 —To outlaw abortions unless necessary to preserve the life of the mother, which determination must be made by two physicians, and to define illegal abortion as a high misdemeanor. *DISAPPROVED*, because the bill is not compatible with the official position of The Medical Society of New Jersey. (Sec. A-757)

A-940 —To extend coverage of the "New Jersey Medical Assistance and Health Services Act" to recipients of general public assistance. *APPROVED*

A-944 —To prohibit storing or dumping materials in a manner that may degrade or threaten to degrade water quality resulting in damage to aquatic life and wildlife. *APPROVED*

A-952 —To amend the law prohibiting use of lead paint to prohibit certain additional uses and to provide a right of action and right to damages to persons affected. *APPROVED*

A-979 —To provide that graduates of foreign medical schools shall not be required to take examinations as a condition of beginning an internship or residency in any hospital of this State. *ACTIVE OPPOSITION*, because this legislation erroneously assumes that all foreign medical schools are the academic equal to American and Canadian medical schools. Its enactment would have a devastating effect on intern and residency training programs in New Jersey. The bill would lead to disaccreditation of those intern and residency training programs, and thus would discourage qualified medical school graduates from applying for training in this State.

Approved (page Tr 135)

Incoming President and Mrs. William J. D'Elia.



# *Administrative Council*

## Medical Services

Louis K. Collins, M.D., Chairman, Glassboro

(Reference Committee "F")

The past administrative year has been a busy one for the Council. Innumerable telephone calls and correspondence have been processed through the Executive Offices; in addition referrals from the Board of Trustees and the House of Delegates placed upon us the burden of several far-reaching decisions. The salient features of our labor are more specifically dealt with below.

### POSITION STATEMENT ON PHYSICIANS' ASSISTANTS

The Board of Trustees referred to the Council a request to adopt a position statement on the topic of physicians' assistants and to correlate the same with the position of the AMA.

The statement adopted by the AMA and reported in the *AM News* is—"A definition adopted in principle classifies the physician's assistant as 'a skilled person, qualified by academic training in an accredited program and by practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant.'"

The Council recommended that definition to the Board along with the request, "That The Medical Society of New Jersey, recognizing the need for qualified persons to assist physicians in the delivery of good health care services to the people of New Jersey, approve and support the adoption of sound and innovative programs for the development and production of appropriate supportive allied health personnel, and support legislation that would remove presently existing legal restraints and thus promote the development and utilization of qualified allied health personnel in accordance with AMA guidelines."

The Board of Trustees concurred in this action with the proviso that these individuals be certified as qualified and not separately licensed.

### RESOLUTION #9 (1971)—LEGISLATION CONCERNING MEDICAL ASSISTANTS

This resolution which was not adopted but referred to the Council for further study called for the enactment of legislation that would afford legal recognition and protection to those persons that provide the indispensable ancillary and allied health services. In view of our previously stated position in this regard, we approved the substance and intent expressed therein. Although A-74 would have effected these ends, it is our understanding that the sponsor has withdrawn it in order to make some pragmatic amendments. I urge all of you to carefully follow the reports of the Council on Legislation in this regard and to give that bill, when it is reintroduced, your active support.

### RESOLUTION #18 (1971)—PHYSICIAN SHORT- AGE AND PHYSICIAN ASSISTANTS

This resolution was "not adopted" by the House of Delegates but was referred by that body to this Council "for evaluation, study, and implementation."

The Council noted that the purpose of the resolution was twofold:

(1) To encourage the expansion of the present medical schools, the establishment of new ones, the reduction of curriculum to three calendar years, and increased production of medical technicians.

(2) To oppose the licensing of physician assistants "by whatever name called."

The Medical Society of New Jersey has been and continues to be clearly on record as vigor-

ously promoting the elements in group number one listed above. We already are pursuing implementation of these goals.

As previously noted in this report the Council and the Board of Trustees have agreed to support sound programs that will make available the services of properly qualified and controlled allied health personnel, including physicians' assistants, to work for and with physicians in the care of their patients. For these reasons the Council unanimously voted to record itself as concurring in the position of "not adopted" taken by the 1971 House of Delegates and does not suggest any new action.

#### RESOLUTION #20 (1971)—RESTRICTION OF P.L. 89-239 TO ITS PROPER PURPOSES

This resolution was "not adopted" by the House of Delegates but was referred by that body to the Council on Medical Services for "evaluation, study, and implementation."

The resolution patently treats of the recent shift of emphasis under Federal law of the thrust of P.L. 89-239 and Regional Medical Programs. There has been a change in policy but it has been effected by Congressional action and is well established and supported. It is the opinion of the Council that it would be beyond the power of either MSNJ or the AMA to achieve a reversion to the old format and limits of the program. Whatever its faults, the Regional Medical Program in New Jersey has achieved appreciable and significant results. The members of the Council, therefore, voted to record themselves as concurring in the position taken by the 1971 House of Delegates of "not adopted." They are of the opinion that no further action is necessary concerning Resolution #20.

#### RESOLUTION #36 (1971)—MSNJ PARTICIPATION IN CERTIFICATE OF NEED ACTIVITIES

The 1971 House of Delegates adopted the following and referred it to the Council on Medical Services.

RESOLVED, that The Medical Society of New Jersey, through its Council on Medical Services or other designated committees, actively engage in these consultative functions, with either the various committees of the Regional Medical Program (Cancer, Stroke, Heart Disease) who formulated the above-mentioned guidelines, or participate and advise by having formal representation on these committees, as has been suggested in writing by the Regional Medical Program of New Jersey.

The Council directed its Chairman to meet with the President to appoint interested MSNJ members to serve as our representatives on the various committees. That action has been successfully completed.

#### PEER REVIEW

Peer review is a frequently used and often grossly misunderstood term. It does not present an entirely new concept but is merely the popularization of an obligation that has been recognized by the medical profession since the Flexner Report. In this regard I urge you to peruse the report we submitted last year dealing with "Formation, Functioning, and Responsibilities of Utilization Review Committees." The concepts presented there are easily adaptable to the entire field of peer review. That report appeared on pages Tr64, Tr65 of the July 1971 edition of *The Journal*. We were pleased to hear of the establishment of the Statewide Peer Review Committee. Four members of the Council serve either as members, alternates, or consultants.

#### EFFICIENT USE OF HEALTH CARE SERVICES

David R. Brewer, M.D., a member of the Council on Medical Services, has attended a Pilot Conference on the Efficient Use of Health Care Services sponsored by the AMA, the AHA, and the National Blue Plans. Dr. Brewer represented the MSNJ. He has recommended, and the Council will consider, the sponsorship of a statewide workshop on this topic in the near future.

My thanks to the Council members for their cooperation and efforts this past year.

Approved (see notation in Reference Committee report—page Tr 137)



# *Special Committee to Council on Medical Services*

## Occupational Health, Workmen's Compensation, and Rehabilitation

Delma W. Caldwell, M.D., Chairman, Linden

(Reference Committee "F")

After several years of relative inactivity, the Committee once again found itself involved with numerous important issues. The items dealt with are discussed in detail below.

### INTERRELATIONSHIP BETWEEN MEDICAID AND THE REHABILITATION COMMISSION— RESOLUTION #21 (1970)

The above-mentioned resolution was discussed with the Medical Director of the Rehabilitation Commission. The Committee is pleased to report that a working agreement has been effected between the Rehabilitation Commission and the Division of Medical Assistance and Health Services (Medicaid). Certain alterations are being made which will be reported to the Society when finalized.

### TREATING EMPLOYEES FOR NON-OCCUPATIONAL ILLNESS

At a recent meeting sponsored by the AMA, the proposal was made that industrial physicians should provide medical services to employees and their families for all injuries or illnesses whether work-related or not. The Committee feels that industrial physicians should restrict their activity to work-related matters or to emergent conditions arising during working hours.

#### Recommendation

That MSNJ take opposition to any proposed ethical change that would allow industrial physicians to render treatment for non-industrial related conditions to employees and their families.

Approved (page Tr 137)

### OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA)

This recently effective Federal Law has far-reaching implications for industrial physicians and also private practitioners who treat patients for employment-related illness or injury. The AMA is setting up a program to supply the up-to-date changes in the law. This Committee believes its responsibility is to review all pertinent materials for summarization and distribution to the general membership. Significant matters will also be offered to *The Journal* for publication.

### COMPREHENSIVE REHABILITATION FACILITIES FOR SOUTH JERSEY

The Committee has learned that the State Rehabilitation Commission is interested in establishing a comprehensive rehabilitation facility in the South Jersey area. The project would be federally and state funded but locally administered. Although the project is still in the early formative stage, the Committee believes MSNJ should record its support and transmit the same to the Rehabilitation Commission.

#### Recommendation

That MSNJ support the concept of the establishment of comprehensive rehabilitation facilities in South Jersey, as proposed by the New Jersey Rehabilitation Commission.

Approved (page Tr 137)

Report Approved (page Tr 137)

# *Administrative Council*

## **Mental Health**

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

The Council had four excellent meetings and its final one offered suggestions for items to be included in this annual report. They comprise three topics:

(1) We continue to be profoundly concerned over the fact that the Governor of New Jersey and the Department of Institutions and Agencies view the Division of Mental Health with so little concern that no active effort has been made to create a separate department of mental health, which the 1970 House of Delegates voted to approve. Worse yet is the fact that the Division of Mental Health continues to flounder without a Director, therefore, without guidance and support. It is apparent that the neglect of the mentally ill within the institutions of the State of New Jersey has had a profound impact on mental health programs throughout the State, and this circumstance affects every physician within our State. We urge every arm within the medical society's province to focus its attention on the plight of the mentally ill in the hope that a separate department of mental health and a qualified Director can be secured.

(2) The Council has spent considerable time this year discussing the "Practitioner's Report of Controlled Dangerous Substance Abuser," reportable to the New Jersey State Department of Health, Division of Narcotic and Drug Abuse Control, Form #DSR-5. We concern

ourselves with the fact that we do not believe this report is as confidential as it should be and as a result physicians cannot guarantee confidentiality to drug users. Consequently, this prevents many from seeking active treatment. It was the consensus of our Council that certain items should be stricken from the report in order to facilitate the treatment of addiction, and we have twice so recommended to the Board of Trustees, but without success. It is not our desire to create ill feeling between ourselves and the Board of Trustees, but rather to express a conscientious concern over the intent and purpose of this reportable procedure which we feel defeats its goal. We would hope that sound deliberation be given to reconsideration.

(3) Finally, our Council has learned that other state medical societies have reported success in operating a dispensary for the legislators, with the indication that more careful consideration is given to medical legislation. At present we seem to have failed successfully to convey the needs for restructuring New Jersey's mental health system to the State government and we believe that the issues pertaining to MSNJ's position could be more favorably pursued if reconsideration of the proposal known as "Doctor of the Day" for assignment to the Legislature were to be effected.

Approved (page Tr 138)



House of Delegates—First Session.

# *Special Committees to Council on Mental Health*

## **Alcoholism**

George A. Rogers, M.D., Chairman, Camden

(Reference Committee "F")

With regular attendance from its small membership, and by means of interested and thoughtful work, the Committee on Alcoholism spent the year struggling to find ways that the Medical Society could assist in improving the level of care for alcoholics.

1. As a left-over item of business from last year, the Committee reformulated a policy statement, which was later adopted by the Board of Trustees, defining the responsibility for alcoholism. The policy statement emphasized the medical responsibility for the physiological facets, and the community responsibility for the sociologic aspects of the problem.

2. There was consideration given to the problem of gaining better acceptance, particularly at the general hospital level, of alcoholics as patients, not only in the acute phase, but also for follow-up treatment. A letter was written to the Joint Commission which, in effect, reminded them of the need to encourage general hospitals to meet this community problem. The Committee is also in the process of obtaining a list of hospitals in New Jersey whose written bylaws prohibit the admission of patients with a diagnosis of alcoholism. We anticipate recommending that the Board of Trustees write to such hospitals, pointing out that such restrictive regulations are detrimental to early and adequate treatment.

3. A most interesting meeting of the Committee was held in January, at which time Mr. James Deans, Executive Director of the New Jersey Alcoholism Council, was present, as was Mr. Charles Betts, representing Alcoholics Anonymous. It was a fruitful meeting and mutually supportive, in that it underlined the unanimity of opinion as to the needs in New

Jersey. Most of the recommendations that Mr. Betts and Mr. Deans made for Medical Society action were recommendations that had previously been made by the Committee. These consisted of: (a) A greater recognition of the public health problem that alcohol constitutes in a budgetary sense (drug addiction, for example, has gotten a disproportionately large share of the funds.); (b) The need for establishing half-way houses which would furnish living places for alcoholics midway between full return to the community and leaving state hospitals or other medical facilities, seemed particularly important; (c) It seemed clear to the Committee, as well as to the representatives of the Alcoholism Council and AA, that it was wisest to separate treatment facilities for alcoholics from general psychiatric facilities; we again emphasized the need to have special alcoholism treatment facilities, with adequate follow-up care facilities, and community connections in each public psychiatric hospital; (d) It was again felt that efforts should be made to get all general hospitals actually to admit alcoholics for detoxification.

4. One of the most important new developments in 1971 was the passage of the national act for comprehensive alcoholism planning, known as Public Law 91-616. Contact was made with Mr. Chamberlain, Coordinator of Alcoholism Programs of the State Department of Health. Mr. Chamberlain indicated that he would be most eager to obtain the Committee's help in formulating the New Jersey's Plan, and would keep in touch with the Committee as to developments. Mr. Chamberlain extended an invitation to the Chairman of the Committee to serve on the State's Advisory Council and the Chairman has accepted.



5. It was suggested by Mr. Deans that the Committee explore the possibilities of improving alcoholism treatment and case-finding via industrial medical programs. The Committee plans to convene a meeting in March, whose

activities will be included in next year's report, and whose major function will be to consider this possibility.

Approved (page Tr 138)

## Drug Abuse

Henry A. Davidson, M.D., Chairman, East Orange

(Reference Committee "F")

Many of the problems associated with drug abuse require changes in our social patterns, international action, changes in the slum culture, and perhaps better police controls. These activities are beyond the power of any medical organization. While we deplore the entry of other well-intended, but often unskilled professional and semiprofessional groups, we must confess that we do need their cooperation and understanding. We note with interest increasing use of the methadone programs, and, while this is no panacea, we do think it worth trying although it is not suitable for unsupervised use in the offices of private practitioners. While we do not favor the legalization of marihuana, we deplore hysterical or panicky over-reaction to the smoking of "pot" by many adolescents.

Our own profession is not entirely without fault in the ease and frequency with which we issue prescriptions for sleeping tablets, mood-elevators, and tranquilizers. We suggest that we discipline ourselves better and cease trying to solve everyone's emotional problems by medication.

We note with interest that our House of Delegates has adopted a resolution to establish, statewide, a confidential registry of drug abusers. While we applaud the purpose of this, we remind the authorities concerned that care must be taken to prevent too easy access to such a registry as it opens the door to abuse of doctor-patient confidentiality.

Also noted with interest is an effort to persuade physicians voluntarily to curtail the prescribing of amphetamines. Certainly this step would reduce the reservoir of amphetamines in our communities, but most drug abusers seem to get their amphetamines through illegal channels anyway, so we must not expect too much from this restraint.

The College of Medicine in our state has taken commendable forward steps in seeing drug abuse as a public health problem, and we commend it for this, and suggest that The Medical Society of New Jersey offer to cooperate in such educational programs. The basic problem of drug misuse among the young seems to be their dissatisfaction with their life style. They see the adult generation as a group of hypocrites who don't practice what they preach and who seem to have plunged the world into all kinds of troubles. They do not approve of our middle-class worship of success, however success is defined. These profound philosophical and sociologic problems are beyond our reach as medical practitioners. But we must face the fact that modern chemistry has done a good deal for mankind. If nothing else, narcotics enable a man rid- dled with metastatic malignancies to die in dignity as well as comfort. Hypnotics do enable an anxiety-ridden person to get the boon of sleep. Tranquilizers have revolutionized the mental hospital. We realize, of course, that such drugs, if abused, also strip a human being of dignity, honesty, and efficiency. Their

thoughtless use allows us to avoid dealing with the basic cause of the symptoms.

In general, physicians have not shown much interest in or sophistication about abusable drugs. There is need for better medical education on the subject, and we suggest that more practical courses at the professional level be

provided. If our profession doesn't take steps here to understand this subject, many other professional and nonprofessional groups will be glad to rush in and fill the vacuum so provided.

Approved (page Tr 138)

## Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus

(Reference Committee "F")

This year the Committee continued to seek means of improving the coordination between the educational system and the medical system in the care of the emotionally and mentally ill child. A brief statement was prepared for dissemination to physicians. This statement outlines the procedure for placing such children in appropriate education programs and suggests avenues of appeal should the placement

not be appropriate.

The Committee records its opinion of the need for increasing significant participation by physicians in school programs and procedures involving mentally and emotionally ill children.

Approved (page Tr 138)

## Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

After consultation with the Division of Mental Retardation of the Department of Institutions and Agencies, the Committee has established a set of criteria to be used by physicians when contemplating a patient referral for admission to one of the State institutions. This will be published in *The Journal* of The Medical Society of New Jersey.

The Committee is also on record as requesting that the State of New Jersey establish a short-term-stay diagnostic center for the sole purpose of establishing diagnoses for the physicians in the State. A letter was presented to the Board of Trustees for transmittal to

Mr. Clifford, the new Commissioner of the Department of Institutions and Agencies. This should be a must project for follow-up next year.

There have come to fruition in our school system a much better program and a higher caliber of classes for the trainable and educable mentally retarded, in large part, because of the continued pressure by the Committees on Mental Retardation and Emotional Disorders of Childhood and Adolescence.

Approved (page Tr 138)

# Neurological and Related Disorders

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

This Special Committee, retitled from the "Special Committee on Seizures," with the approval of the Council on Mental Health and the Board of Trustees, met on two occasions with enthusiastic attendance and the presence of the Executive Assistant of the Society. It concerned itself with a redefinition of its goals and mandates and dedicated itself to the meaningful delineation of neurological and allied disorders for our members and the public, in the interest of the general welfare.

It was emphasized that, probably more than any other branch of medicine, neurology has been traditionally related to mental illness and health. The close relationship between the brain and mental functioning has always been recognized. The rapid development and expansion of the voluntary health agencies concerned with specific disorders such as multiple sclerosis, cerebral palsy, poliomyelitis, muscular dystrophy, myasthenia gravis, and paraplegia have given impetus to clinical investigations, diagnosis, and treatment. The formation of a National Institute of Neurologic Diseases in the United States Public Health Service and the rapid expansion of its program have emphasized the importance of neurology and have increased public awareness of it. The inclusion of a Special Committee on Neurological and Related Disorders in the Council on Mental Health is further confirmation of the usefulness of the role that such information and activity may offer.

Mindful of the vastness of the fields of neurology and neurosurgery, our Special Committee will devote itself to a necessarily limited range of subjects. Many neurological disorders abut on mental health parameters such as multiple sclerosis, the epilepsies, brain tumors, muscular dystrophies, cerebral atrophies, the encephalitides, hereditary degenerative disorders,

and post-traumatic states, to name only a few. It is not the function of the Special Committee to classify neurological and allied disorders but rather to study the public health, education, prevention, and management of these disorders and to inform all who are interested through the Council on Mental Health and the Board of Trustees.

The Committee pledged its attention to brain-injured patients, either from stroke, trauma, senility, or disease. Emphasis was placed on the triad of 1) neurological observation, diagnosis, and medical intervention, 2) extended care with physical therapy, and 3) after care—domiciliary care, whether in an institution or home. The Committee will try to concentrate on modern day measures of neurological evaluation and psychotropic medications as alternatives to treatment in remote psychiatric facilities and to press for imaginative plans for care in home settings, such as infirmaries in multiple apartment units, rehabilitation units, and clinics. Finally the Committee will explore the interest and involvement by federal and other agencies in neurological disorders, which are so often catastrophic and permanent.

Approved (page Tr 138)

## Support

The Society for Relief  
of Widows and Orphans

P. O. Box 95  
Belleville, New Jersey 07109



# *Administrative Council*

## Public Health

Robert G. Salasin, M.D., Chairman, North Wildwood

(Reference Committee "G")

The work of the Council on Public Health has been greatly expedited by the efforts of the special committees to the Council. Consequently following the report of the Council will be the specialized reports of the committees giving detailed accounts of the items originating at their level.

### U. S. GOVERNMENT MEAT AND POULTRY INSPECTION PRACTICES

The New Jersey Public Health Association requested The Medical Society of New Jersey's support of its protest and that of the American Public Health Association against certain U.S. government meat and poultry inspection practices. The Council approved of their position in essence and recommended that The Medical Society of New Jersey join in that protest. The Board of Trustees disapproved, stating that greater efficacy in this area would be achieved through public education by State and Federal health agencies and that since the New Jersey Public Health Association and the American Public Health Association had already communicated with the United States Secretary of Agriculture, a letter from MSNJ would be needless duplication. It was also noted that the State Health Department conducts an ongoing public education program in this regard. The Council accepted these explanations.

### JOINT RESOLUTION ON ACCREDITATION OF HOSPITALS

The Council again requested the Board of Trustees to urge the Joint Commission to conduct a confidential survey of the staff physicians of a hospital prior to the evaluation of the institution itself. The Board felt that such a procedure might result in more harm than good. It, therefore, directed a

communication to the Joint Commission indicating that an open meeting with the hospital medical staff should be a part of every survey.

### AMA RESOLUTION #51—"CONTROL OF VENEREAL DISEASE"

The AMA Communications Division requested information from the state societies as to the demand for VD educational materials such as slide presentations, posters, etc., to be used in local education programs. The Council referred the material to *The Journal* in the hope that it will stimulate the membership to become active in the control of venereal disease.

### PHYSICIAN REPORTING OF COMMUNICABLE DISEASES

The Department of Health has advised the Society it will begin actively to enforce the reporting statutes relevant to venereal disease and hepatitis. Available statistics indicate that while the reporting of syphilis has been markedly inadequate, that of gonorrhea has been woeful. Hepatitis likewise is going largely unreported. All physicians should understand their obligation to the public health and their duty to comply with the law. We urge you to report these cases, as they manifest themselves in your practice, to the Department of Health.

### IMMUNIZATIONS

The State Public Health Council and the State Department of Health are in favor of legislation that would repeal the authority of local school districts to mandate immunization of children against stipulated diseases prior to their entry into the school system.

The Department of Health and the State Public Health Council believe this authority should be transferred to the State Public Health Council. Immunizations would then be mandated by promulgation of rules under the State Sanitary Code and would thus be uniform statewide. Likewise changes indicated by the advance of medical science could be more speedily effected. Our Council concurs in this position and requested the Board to transmit these sentiments to the State Public Health Council and the State Department of Health. The Board did so in February.

Since, at the time of this writing, the Council has scheduled a meeting for late March it may well be that a supplementary report will be necessitated to cover our final actions.

I wish to thank the Council members for their diligence and faithful attendance during the past administrative year.

Approved (page Tr 140)

## *Special Committees to Council on Public Health*

### Cancer Control

Roy T. Forsberg, M.D., Chairman, Westfield

(Reference Committee "G")

The Committee on Cancer Control met once in December 1971. It was agreed that in 1972 we shall prepare a tape-slide program for possible use in the schools of New Jersey. The program is to deal with smoking and its hazards.

In addition, the Committee is to prepare short articles for newspaper release. These are to be geared for the lay public, and hopefully released on a monthly basis throughout the State.

Approved (page Tr 140)



Head Table—Banquet honoring President Davis.

# Child Health

William J. Farley, M.D., Chairman, Nutley

(Reference Committee "G")

Discussion and review of issues relating to child health included recent policy concerning smallpox vaccination, medical participation in child study teams to coordinate educational programs of the handicapped child, and the desirability of MSNJ's establishing a Comprehensive Health Planning Committee to assist existing governmental planning agencies. Major activities included the following programs:

## THE HOSPITAL PERINATAL STUDY CONFERENCE

A favorable response was obtained in the use of the "Suggested Guide for Hospital Perinatal Study Conferences" with return of questionnaires from New Jersey hospitals. Each hospital through the Chairman of its joint Obstetrical-Pediatric or Perinatal Committee has been urged to review its 1971 experiences and return the Perinatal Statistical Review Form. The primary goal of this statewide program is to encourage the examination of perinatal problems in each hospital by its medical staff through regular study conferences.

## CHILD ABUSE

A program to promote greater participation and concern for the problems of the battered

child and his parents by New Jersey physicians has been developed.

(1) A small brochure entitled "Doctor, You May Save A Child's Life," aimed to alert the physician to recognize the abused child and the urgent need for help will be sent to each New Jersey physician.

(2) A "Guide for the Medical Management of Child Abuse" has been prepared in outline form to provide a more comprehensive review of the problem, the recognition of the battered child, the appropriate handling of the parent, and the reporting procedures and legal responsibilities of the physician under present New Jersey State laws. The Committee has proposed that the Guide be sent to the emergency room of each hospital in New Jersey and to all those that request it. Publication of the Guide in *The Journal* of The Medical Society of New Jersey is also anticipated.

Approved (page Tr 140)



Dinner-Dance in honor of President Davis.



# Conservation of Vision, Hearing, and Speech

(Reference Committee "G")

Due to the regrettable and untimely death of Frank B. Vanderbeek, M.D., Chairman, this report is being submitted by the Executive Offices as a summarization of the Committee's efforts during the past year.

## 1971 EYE HEALTH SCREENING PROGRAM

This year 86 centers participated in the program. There were 12,481 persons screened. Of that number 7,169 negative results were obtained and 5,312 positive results were presented. There were 520 tonometry suspects. Follow-up has established that there were 19 positive glaucomas and 7 suspect glaucomas. The 1972 Eye Health Screening Program will be conducted during the week of 11 September 1972. In addition, we have requested the Commission for the Blind to have a number of signs announcing the program printed in Spanish.

## CONTROL OF EYE MEDICATION—OPTOMETRISTS

The Committee is pleased to note that the Society has drafted a bill to prohibit the use

of eye medications by optometrists. The New Jersey Academy of Ophthalmology and Otolaryngology has agreed to seek a sponsor for the proposed legislation.

## SCHOOL HEALTH SERVICES

The Committee has been working closely with the State Department of Education for the purpose of setting up a program on "Screening for Hearing." The Committee is also preparing suggested revisions for that section of the State guidelines that deals with vision screening.

## CONSULTANTS TO THE COMMITTEE

At your Committee's request, the Society has adopted the policy of inviting the President and President-Elect of the New Jersey Academy of Ophthalmology and Otolaryngology to serve as consultants to the Special Committee on Conservation of Vision, Hearing, and Speech.

Approved (page Tr 140)

# Environmental Health

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")

The Committee held a liaison meeting with the New Jersey State Department of Health to review an air pollution incident in Piscataway involving adolescent athletes. Study of this problem is continuing to develop means to prevent future incidents and to bring pertinent clinical information to the physicians.

A representative of our committee attended the Regional Meeting of the AMA Council on Environmental Health and presented

there a comprehensive report of this committee's activities since 1965.

Testimony was given at the Clean Air Council Public Hearing on the need for (1) an Environmental Health Center, (2) Mass Transportation, (3) Non-polluting vehicles, (4) Modification in Highway Usage, (5) Hazards from Nuclear Power Plants, and (6) Urgency to develop Recycling in Industry and Solid Waste Disposal.

A communication from the Board of Trustees to the New Jersey College of Medicine and Dentistry, the Department of Environmental Protection, and the State Department of Health of New Jersey, urging them to coordinate their efforts in establishing a joint project to utilize the resources of each in the problems of air pollution and health, has brought responses which are leading to meaningful discussions to be initiated by this committee and the aforementioned groups.

The committee has also concerned itself with hazards from ozone toxicity, arising from home and institutional air purifiers.

The committee is sponsoring an exhibit on environmental health which will be shown at the 206th Annual Meeting of MSNJ.

Approved (page Tr 140)

## Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

### MATERNAL DEATHS

The Committee reviewed the statistics on maternal deaths for the years 1970 and 1971. In 1970 there were 49 maternal deaths and completed reports were submitted for 48 of them. During 1971 there were 38 recorded maternal deaths with 37 completed reports being filed. The one outstanding case is currently under investigation. These statistics are particularly revealing when one considers that the birthrate was higher in 1971. You will recall that last year, at the request of The Medical Society of New Jersey, the State Department of Health assigned a physician to the position of field investigator. We are pleased to note the extraordinary number of completed reports that have resulted from that action.

The Committee will prepare articles on the significant cases for submission to *The Journal* during the upcoming year with the hope that the entire membership may derive benefit from our review.

### COMPLICATIONS OF ABORTIONS

Since November of 1971, complications resulting from abortions are to be reported to the State Department of Health by the physician

treating the complications or the one performing the abortion. We bring this to your attention because many physicians mistakenly believe that only maternal deaths are to be reported.

### RH AND BLOOD TYPING

The Council on Public Health referred to this Committee the question of whether or not RH factor and blood typing should be performed routinely on all pregnant females at State expense. The Committee feels this is especially desirable in view of the increasing utilization of RHOGam. We have, therefore, requested that the Board of Trustees inform the Department of Health that routine determinations of RH factor and blood type should be performed on all pregnant females upon the order of their treating physician and at State expense.

Amended by the Reference Committee by adding "when necessary" to the last sentence, to read: We have, therefore, requested that the Board of Trustees inform the Department of Health that routine determinations of RH factor and blood type should be performed on all pregnant females upon the order of their treating physician and at State expense, when necessary.

Approved as amended (page Tr 140)

# *Administrative Council*

## **Public Relations**

John J. Crosby, Jr., M.D., Chairman, Jersey City

(Reference Committee "E")

This year the Council on Public relations considered a referral from the House of Delegates (1971) based upon two resolutions (#7 and #22) which concerned themselves with the expansion of PR activities through engagement of outside professional public relations assistance. Reference Committee "E" considered the two resolutions together, amended Resolution #7, and recommended that it be adopted as amended. The House tabled the amended resolution and referred it to the Council on Public Relations "for further detailed study."

After careful consideration of the two resolutions, the Council agreed to direct letters to selected professional public relations agents inviting them to meet with the Chairman of the Council to discuss the feasibility of their serving as special PR Council and Program Coordinator. They were to be asked to suggest expansion of, and improvement upon, the Society's present PR activities, especially in connection with the annual meeting. They were also to be asked to consider additional PR services to the Society in the course of the year, as circumstances seem to indicate the need for added PR activities. Each person interviewed was to be asked to present his qualifications and suggestions, together with an estimate of the costs that would be involved for the projected services.

The letters of invitation were sent and five noted PR professionals were interviewed by the Chairman of the Council on Public Relations, the Executive Director and the Executive Assistant.

Mr. Edward Meara is the President of Daniel Edward, Incorporated, a Trenton-based organization of advertising, public relations, and legislative consultants. He is presently the Legislative Counsel and registered representa-

tive to the New Jersey Legislature of The Medical Society of New Jersey. His office is at 224 West State Street, Trenton. He serves the Society in his present capacity on the basis of a modest monthly retainer plus fee for service compensation for extra assignments—such as the recent preparation and placing of a paid advertisement in all New Jersey dailies, urging the public to give donations of blood during the holiday season.

Because Mr. Meara already is working satisfactorily with MSNJ in its legislative endeavors, because he is well prepared to add special PR support for our Society's positions in the legislative and health care fields, because he is expertly qualified, conveniently at hand, is amenable to our plans for careful study of present programs and judicious expansion of PR activities, and finally because he is willing to work for terms similar to those presently in force between him and MSNJ, on advice of the Chairman, the Council agreed to recommend that the Board of Trustees engage Mr. Meara to serve in the dual role of Legislative and Public Relations Counsel, at least from March 1 through May 31 of this administrative year, with first emphasis to be placed on the improvement of PR activities at the 206th Annual Meeting. The Board approved that recommendation.

In fulfillment of its assigned functions, the Council this year reviewed and approved, with Board concurrence, the following:

### CONTINUING PROJECTS 1971-72

#### 1) Publication and distribution of:

- a) *Junior Health Hints* to schools and public libraries.
- b) *Membership Newsletter*, including the annual compilation and distribution of a bound, indexed set to component societies.
- c) *Periodic Newsletter* to cooperating agencies/individuals as required.



2) Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interests, and activities, including:

- a) The Eye Health Screening Program.
- b) The Annual Meeting.
- c) Child Safety Week.
- d) Selected official programs and activities.

3) Responsibility for bestowal of the Golden Merit Award.

4) Responsibility for the informational center and issuance of press releases at the annual meeting.

5) Encouragement of continuance—or establishment—of orientation programs for new members under the sponsorship of component societies.

6) Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the "Appendix of Reference Information" of the *Membership Directory*.

7) Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level.

## GOLDEN MERIT AWARD

The 1971 Golden Merit Award was bestowed upon 48 members of the Society, 24 of whom received the award personally in Atlantic City. This brings the total recipients of the Golden Merit Award since its inception in 1957 to 656. Thus far this year, 31 candidates have been nominated for the 1972 Golden Merit Award. The ceremonies this year have been rescheduled for 12 noon. Following the ceremonies, recipients and their immediate families will be guests of the Society at an informal reception, at which members of the Council on Public Relations will serve as hosts, as they have in preceding years.

Approved with commendation (page 135)



Scientific Session.

## *Special Committees*

### **Emergency Medical Care**

**Jack R. Karel, M.D., Chairman, Hillside**

(Reference Committee "D")

Emergency health care occupies a vitally important position. Response to health emergency—whether it be in the form of a community disaster or an individual episode—is a critical testing point for a health care system. Tragically, few communities are adequately prepared to pass the test. There have been increasingly heavy burdens imposed on hospital emergency rooms, ambulance and rescue services, and the like in recent years. In view of the above, The Medical Society of New Jersey has taken the leadership in the State of New Jersey to effect various programs to improve the current emergency medical care system.

The Training Program for Emergency Department Physicians sponsored by MSNJ in cooperation with the Division of Emergency Health Services, USPHS, and other medical associations has resulted in the publication of a booklet "Physicians In Hospital Emergency Departments," now in its second printing. Five thousand copies have been distributed nationally and have become very popular. In New Jersey copies have been sent by the Society to every member of the American College of Emergency Physicians. This booklet may be obtained from the national office of the Division of Emergency Health Services, USPHS, 5600 Fishers Lane, Rockville, Maryland 20852.

A statewide Survey of Emergency Departments of Hospitals in New Jersey conducted by the Special Committee on Emergency Medical Care in cooperation with Region II, Division of Emergency Health Services, has produced the following conclusions: The findings of this survey hint at marked deficiencies in many aspects of the field of emergency medical care. Emergency departments of hospitals have not been given their proper status in relationship

with other departments of hospitals. There is a tremendous vacuum with regard to communications between hospitals, between hospitals and ambulances, and between hospitals and other community agencies.

The emergency department must be separate and distinct from the outpatient department. Proper equipment and trained personnel must be provided to minimize transfer of patients. The general public and mass media must be educated as to capabilities of emergency departments in the state. Emergency Medical Care must be placed in its proper perspective and receive the priority status that has been afforded education, ecology, transportation, and the urban crisis. Copies of this report were sent to Governor Cahill; State Health Commissioner James R. Cowan, M.D.; Henry C. Huntley, M.D., Director, Division of Emergency Health Services, USPHS; the State Commissioner of Transportation; and the U.S. Department of Transportation.

The MSNJ has continuously emphasized the importance of road signs on major highways and thoroughfares indicating location and names of the nearest hospitals.

The MSNJ has adopted a policy statement recommending that all medical ambulance attendants in New Jersey complete the emergency ambulance training as outlined and recommended by the U.S. Department of Transportation basic training program for Emergency Medical Technicians-Ambulance or its equivalent, and that qualified instructors for this program be physicians, who may be assisted if necessary by trained allied medical personnel.

A training program for Emergency Department Nurses was cosponsored by our Society

with the Rutgers University School of Nursing, and it is being conducted in each of the Society's judicial districts.

The Board of Trustees approved the recommendation that every general hospital in the state be urged to subscribe to the Hospital Reserve Disaster Inventory Program conducted by the Division of Emergency Health Services, USPHS.

Since emergency medical care recognizes that abuse of drugs has contributed significantly to difficulties in hospital emergency rooms, the Board of Trustees issued a policy statement declaring that physicians should carefully scrutinize the prescribing of all drugs having a potential for abuse.

As a follow-up to one of the conclusions of the Survey of Emergency Departments of Hospitals, the Board of Trustees approved the recommendation to make the general public aware of the necessity of updating emergency medical care by physicians and especially hospitals. To accomplish this, the MSNJ, in cooperation with Region II, Division of Emergency Health Services, will undertake a statewide all-out public education effort to alert the general public through every type of mass media—newspapers, radio, television, and various agencies and associations. One area necessitating immediate action is the Emergency Medical Identification concept, making every individual aware of the necessity of carrying on his person identification of his own personal medical problem. This would ensure his obtaining proper medical aid when needed. Not only do we seek to increase the individual's awareness of his medical problems, but also to increase the understanding of those who provide primary medical care. When completed this program will be a major accomplishment within New Jersey and the first program of such magnitude in the United States.

Faregoing paragraph amended by inserting the word "help" before the word "ensure" in line 18—the sentence would read: This would help ensure his obtaining proper medical aid when needed.

Since New Jersey is the most urbanized state in the nation and the need for the availability of adequate emergency communication service on major highways and thoroughfares is evident, the Board of Trustees approved the recommendation for the installation of emergency telephones on these highways. This recommendation has been forwarded to the State Department of Transportation and the New Jersey Bell Telephone Company.

A landmark program has been approved by the Board of Trustees for activation. The MSNJ, as the parent medical organization in the state will initiate the formation of a "blue ribbon" Ad Hoc Committee on Emergency Medical Services. This Committee will be composed of representatives from the Special Committee on Emergency Medical Care of MSNJ; Committee on Trauma, American College of Surgeons; New Jersey Chapter, American College of Emergency Physicians; New Jersey Orthopaedic Society; American Academy of Family Physicians, the State Department of Health, and Region II, Division of Emergency Health Services, USPHS.

The purpose of this Committee is to unify all agencies and organizations in New Jersey concerned with the total spectrum of emergency health services into a cohesive, effective body to improve the current emergency health care system. This Committee will attempt to delineate responsibilities of the participating organizations, conduct studies, issue public reports on the status of emergency health service in the state, recommend standards and the implementation of programs to upgrade the Emergency Health Services System in this most highly urbanized and densely populated state in the nation.

**Approved as amended (page Tr 133)**

The Special Committee on Emergency Medical Care has recommended sponsorship of a Training Program for Medical Technicians—Emergency Department (Hospital). MSNJ would co-sponsor this program with one or more colleges in the state to conduct a two-



year program in the basic sciences, clinical science, and intensive training in the Emergency Department. This trained individual has been categorized between the licensed practical nurse and the nurse's assistant by the Federal Civil Service Commission. With the addition of one more year of appropriate training this individual, it is hoped, could be eligible for a nurse's certificate or to go on to other allied or professional medical fields. Properly trained medical technicians are needed in hospital emergency departments.

This program would be a boon for those unemployed medical corpsmen of the armed forces and for others seeking their niche in society. Several details and problems must be worked out before the program will be offered for implementation.

*With reference to the preceding paragraph (beginning on p. Tr 84), the House first voted to accept the Reference Committee amendment to delete the next to the last sentence; subsequently the House voted to postpone indefinitely consideration of the last paragraph in its entirety. (page Tr 133)*

## Medicine and Religion

Luke A. Mulligan, M.D., Leonia  
(Reference Committee "D")

This Committee held no formal meetings in the course of the year. We have continued to encourage the establishment of efficient operation of committees on medicine and religion in all component societies. Response has not been uniform but a number of counties report successful cooperative efforts on the part of their physicians and clergymen.

On Saturday, 26, February, at the Sheraton Inn at LaGuardia Airport, the Department of Medicine and Religion of the American Medical Association held a luncheon workshop for chairmen of state society committees on medicine and religion. The meeting was

well-attended and your Chairman represented MSNJ's Committee. The workshop sessions reviewed and evaluated the climate for cooperation between medicine and religion, considered what and how further progress could be made toward the realization of joint goals, and discussed plans for a session on medicine and religion at the AMA Annual Convention in San Francisco in June. As yet the program for the AMA Convention has not been announced.

Approved (page Tr 134)



Dinner Dance

## Physicians' Relief Fund

Joseph J. Kline, M.D., Chairman, Trenton

(Reference Committee "B")

The Committee on Physicians' Relief Fund presented its Rules, Manual, and Application Form to the Board of Trustees, and with some minor modifications received the approval of the Board. We are hopeful that we will be in a position to consider applications by 1 June 1972.

The salient features of our program are as follows:

All members in good standing, their dependents, and dependents of deceased members are eligible to apply for aid if, because of illness, accident, age, or other disability, they are not self-sustaining.

Applications must originate in and be approved by the component society to which the member belongs or belonged.

Each component society will appoint a local investigator who will assist the applicant in completing the necessary forms.

The local investigator and the component society will recommend the amount of the grant. The grant will be determined by the

Committee on Physicians' Relief Fund after due consideration of all relevant materials. Grants are to be awarded to meet emergency needs and are not meant to be pensions or annuities.

Grants may be made for a period not to exceed six months. Extensions may be authorized for an additional six months. A grant will not be renewed without the completion of a new application form. All grants terminate upon the death of the beneficiary. All payments will be made in monthly installments.

An adequate supply of all necessary forms will be made available by this Committee to the governing bodies of all component societies. The component society will receive timely notice of all final actions on the applications forwarded to the Committee.

Please be advised that it is not the intent of this program to replace the Widows and Orphans Fund. We urge all members of the Society to become sustaining members in that most worthwhile cause.

Approved (page Tr 131)

## Project Hope/Vietnam

Thomas C. DeCecio, M.D., Chairman, Cliffs'de Park

(Reference Committee "B")

In 1968, the House of Delegates voted to approve the recommendation of the Board of Trustees, "That Project Hope and Vietnam be established as a joint continuing program of The Medical Society of New Jersey, subject to any subsequent modification by the House of Delegates; and that a maximum of six fellowships be awarded annually on a 'first-come, first-served' basis, each carrying a

stipend of \$1,000 for a 60-day tour of duty aboard the S.S. Hope, her sister-ship, or voluntary service in Vietnam." To date the Society has awarded a total of seven Project Hope Fellowships and two Volunteer Physicians for Vietnam Fellowships.

During the year 1971-72, the following application was received and authorized:

## PROJECT HOPE FELLOWSHIP

*John J. Flanagan, M.D.* (Monmouth County) . . . \$1,000—Doctor Flanagan served for two months on the S.S. Hope in Kingston, Jamaica. In consequence of that service, Doctor Flanagan qualified for a grant of \$1,000 under the program. However, Doctor Flanagan applied for the grant with the stipulation that the money be donated to Project Hope (The People-to-People Health Foundation in Washington, D. C.) by The Medical Society of New Jersey in his name. Meeting on 16 January 1972, the Board of Trustees acted favorably upon Doctor Flanagan's application and granted his request.

At its January meeting, the Board referred to the Committee the question as to whether the original intent of the program was to award the fellowship prior to departure for service on the S.S. Hope, her sister-ship, or in Vietnam.

By means of a mail questionnaire, the Chairman undertook to develop the opinion of the Committee members. The substance of the thinking of the Committee was:

1. That normally an individual should apply for the grant before he enters upon the service, but that the actual payment of the grant should be made after the service has been completed. In exceptional circumstances, under which the physician who entered upon the service would suffer financial hardship, prepayment of the grant should be made at the discretion of the Special Committee on Project Hope and Vietnam, with the concurrence of the Board of Trustees.

2. That an individual should be eligible to receive the grant only once in any one year.

At its 19 March 1972 meeting, the Board agreed to adopt the foregoing regulations for future Project Hope and Vietnam fellowships.

Approved (page Tr 131)

## Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

Both the official Retirement Fund Plans—namely, Prudential Insurance Company and the PRO Services Inc.—report active society membership participation. Both Plans have great flexibility and both report that most of the interest is being engendered in incorporation plans.

The current information is that the present Nixon administration is proposing pension reform legislation which will increase allowable Keogh contributions to approximately 15 per cent of earned income, or a maximum of \$7,500. This legislation has high priority but realistically may not be moved in this election year. Its enactment may affect incorporation plans in the near future.

### PRO SERVICES INC.

Total Keogh Accounts in New Jersey—968 (Doctors & Employees) Total Professional Associations—47.

We have 9 agents servicing these accounts and they are currently working with about 60 different groups in different stages of incorporation. We have not added many new Keogh Plans, but have seen increased activity in Corporate Plans. Messrs. James Vaughn, Thomas Kearney, John Devine, George Peterson, Mike Schonberger, and Pat Brady are working primarily in North New Jersey and Messrs. Charles Turner, Bill Cronin, and Richard Hartley are working in South Jersey.



We are actively supporting the Nixon Administration in regard to their proposed pension reform legislation. Included in this proposed legislation is an increase of allowable Keogh contributions to 15 per cent of earned income or \$7,500 whichever is less. In a recent interview, Honorable Hugh Scott (R.-Pa.), the Senate Minority Leader, indicated that this legislation is a high priority item for Congress to consider this year. However, realistically in an election year we are not overly optimistic about its passage. We have written letters to our legislators urging its passage. We will keep the Societies informed of any progress in this area. This legislation as proposed will have a marked effect on incorporation plans, and we urge physicians considering professional associations to keep this possible change in mind.

PRUDENTIAL INSURANCE COMPANY  
HR-10 (KEOGH) VARIABLE ANNUITY  
RETIREMENT INVESTMENT PLAN

The Medical Society of New Jersey Retirement Plan Trust A was established by the Society in 1970 to provide for all members of the State Society the Keogh Program of the Prudential Insurance Company of America, featuring the group Fixed-Dollar Annuity and the group Variable Annuity, with E. & W. Blanksteen Agency, Inc. as Administrator. This program had originally begun in Essex and Union Counties, where it had achieved widespread acceptance by the members.

The program includes three unique advantages in addition to the well-known tax saving and tax shelter features of the Keogh Law:

- 1) A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity.)
- 2) A death benefit guarantee, so that if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.
- 3) Flexibility during accumulation years, permitting the allocation and transfer of funds, at option of the insured, to and from the common-stock account and the fixed-dollar account.

Internal Revenue Service approval for the Master Plan (with Serial Number 701115) was received November 30th, 1970.

Throughout the State we have 242 plans in effect, covering 332 people, with \$1,283,944.05 deposited by members of this program since inception.

CORPORATE MASTER RETIREMENT PLAN

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Trust Plan-B, which adopted a Corporate Master Retirement Plan using the same funding agents as the Keogh program described above. This program in the form of a Master Profit-Sharing Plan permits corporations, one of whose employees is a member of the Society, to place up to 15 per cent of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity. Some of the useful and valuable features of this Master Plan are described below:

- 1) Eligibility Requirements—Employment 0 to 5 years Minimum age up to 30.
- 2) Flexible Retirement Date—(especially valuable for older corporate officers).
- 3) Choice of contribution formulas including *Social Security integration*.
- 4) Vesting can be as minimal as nothing for the first five years under the plan and then 10 per cent a year for the next ten years.

This plan is administered by E. & W. Blanksteen Agency, who will be pleased to furnish members with full information concerning this plan which should provide a substantial saving, since it is not necessary to have a plan and trust especially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan including that of our administrator.

Approved with commendation (page Tr 132)

# Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

By virtually all measurable standards, 1971 was a year of progress and growth for Medical-Surgical Plan. The end of the year saw the Plan's finances in a generally stable condition.

Progress was noted in the following areas:

*Enrollment*—over 79,000 persons were added to the Plan's membership, bringing the total to 3,493,548, or 48 per cent of the State's population. The Plan maintained its position as fourth largest Blue Shield Plan in the nation.

*Benefits*—claims incurred for physicians' services amounted to nearly \$87 million, an increase of approximately \$7 million over 1970.

*Medical, Surgical, and Obstetrical Services*—the total number of services paid for by the Plan was 2,159,260, up 60,000 from 1970.

*Participation by Physicians*—the Basic Program gained 362 fully-licensed physicians as participants, bringing the total to 7,769; the number of all Participating Physicians and Laboratories at year's end was 8,238, a gain of 365 over the preceding year. In the Prevailing Fee Program, a substantial gain of 560 fully-licensed New Jersey physicians was registered. However, the total number of such participants—6,319—must be further increased. A high level of participation is necessary to make the program desirable, at a higher premium than Basic coverage, to subscribers who expect widespread availability of the paid-in-full advantages of Prevailing Fee through widespread participation by physicians. In other words, greater participation means that more groups will take Prevailing Fee, and more doctors will receive their usual and customary fees for more cases.

Improvements were accomplished in services to physicians and subscribers:

*Claims Processing*—by the end of 1971, ap-

proximately 94.5 per cent of claims under Basic and Rider coverages were being paid within 15 or less calendar days. Simplified claim forms for OB, GYN, and surgical services—easier for the physician's office to complete and enabling faster payment by the Plan—were introduced, but their usage by the profession was disappointingly low. Increased use of these time-saving forms, along with simplified forms for anesthesia and medical care, introduced in 1972, would benefit physicians and the Plan alike.

*Inquiry Services to Physicians and Subscribers*—physicians' telephone inquiries rose from 50,000 in 1970 to over 64,000 in 1971, but year's end of 1971 saw the average number of unanswered inquiries reduced from 1,587 to 1,150 or 27 per cent. . . . In correspondence, unanswered inquiries were reduced by 35 per cent during 1971, and the percentage of correspondence cleared within 48 hours more than doubled.

The past year saw Medical-Surgical Plan installed as tenant with Hospital Service Plan in a new headquarters building at 33 Washington Street, Newark. Both Plans had outgrown their previous Newark headquarters and had overflowed into three other downtown and two suburban locations. The new quarters have made it possible to bring all the operations of both Plans under one roof, with adequate space, resulting in improved efficiency and economy.

During the year there were some changes in the Board of Trustees. Mr. John Kelley, sub-district director, United Steelworkers of America, District 9, was elected to the Plan's Board of Trustees for a three year term. He has been an active and contributing member of the Board and the committees on which he serves . . . Elton W. Lance, M.D., a leader in the formation of the Plan prior to 1942, and its first President, retired from

the Board as a Trustee. Fortunately, the Plan continues to enjoy the benefit of his wisdom and counsel as a Trustee Emeritus. . . . The Board suffered grievous losses in the deaths of three outstanding Trustees in 1971 and early 1972. Edwin T. Ferren, D.O., who had been a Trustee since 1964, died on March 20, 1971. Dr. Ferren was the first Doctor of Osteopathy to serve on the board. Jesse McCall, M.D., long a leader in his profession and community, passed away on January 14, 1972. A past president of The Medical Society of New Jersey and chairman of its Legislative Council and speaker of the House of Delegates, Dr. McCall had contributed greatly to the guidance of Blue Shield as a dedicated Trustee since 1962. Another distinguished medical and community leader, Dr. Jerome G. Kaufman, who was also a past president of The Medical Society of New Jersey, a Blue Shield Trustee since 1959 and first vice president of the Board for many years, died on April 1, 1972.

One problem area during the year was the greatly increased utilization of Rider J, which was introduced in 1961 after approval by The Medical Society of New Jersey. The purpose was to make available to subscribers x-ray and laboratory services, among others, as part of ambulatory care. It was felt that if a subscriber's laboratory services were covered by the Plan, when he went to the doctor's office he would be responsible only for the charges made by the doctor for his examination. The Rider was never intended to pay for, or partially subsidize, the charges of the physician for his examination, nor to pay for services that were incident to an annual physical examination, nor for services which were not indicated by the provisional diagnosis on the claim.

The present premium for Single Rider J coverage is \$1.16 per month. It must be perfectly obvious that Blue Shield, or any other insurance company, cannot pay for an EKG, chest x-ray, sigmoidoscopy, SMA-12, complete blood work-up, and urine examination as part of an annual check-up for a premium of only \$13.92 a year; nor can the Plan pay for an

EKG, chest x-ray, sigmoidoscopy, thyroid test, urinalysis, and blood work-up when the provisional diagnosis on the claim is simply "external hemorrhoids." This is well understood by the vast majority of physicians.

Over-utilization problems connected with Rider J are mostly caused by physicians who continue to submit claims for Rider services which are connected with annual physical examinations, and who routinely order a large battery of tests for every patient regardless of the provisional diagnosis.

Then there are physicians whose charges to the Plan for outside laboratory services are much greater than the charges to them by the laboratory. The Judicial Council of the American Medical Association states, "If reliable quality laboratory services are available at lower costs, the *patient* should have the benefit of the savings. As a professional man, the physician is entitled to fair compensation for his services. He is not engaged in a commercial enterprise and he should not make a markup, commission, or profits on the services rendered by others."

Rider J is an important and valuable diagnostic benefit to our subscribers. The Plan has to limit its payments to eligible services so that the Rider may continue to be sold at a price people can afford and are willing to pay for the diagnosis and treatment of current illness. Only then can the Plan consider expanding its coverage to include routine examinations and other increased Rider coverage.

At the present time one of the great issues before Congress is the establishment of utilization controls for medical services. Frequent headlines state that the rapid escalation in the cost of medical care is due principally to rising doctor's fees. This is not true. Over 90 per cent of the physicians in the nation are guided by usual, customary, and reasonable fees for their services. The escalation in the cost of medical care is due primarily to increased utilization of physicians' and hospi-



itals' services, caused in part by many persons receiving more adequate medical care than formerly under Medicare and Medicaid and expanded voluntary insurance programs.

However, abuses by a few doctors who charge excessive fees, and overutilize inpatient and outpatient services, are definitely under surveillance by Congressional committees. Therefore, it is urgent that the medical societies set up adequate peer review mechanisms that will be concerned with these matters, and act forcefully and drastically when abuses are discovered. There is no area within the province of medical societies where forceful and courageous leadership is more urgently needed. If we do not do it ourselves, the government will.

In closing, I wish to express my deep appreciation for the enlightened guidance provided by the Board of Trustees, the loyal support of

the Plan's Staff, and the dedicated cooperation of the Participating Physicians who make Blue Shield service benefits possible. It was my privilege during 1971 to attend many meetings of the Board of Trustees and the Legislative Council of The Medical Society of New Jersey, as well as meetings of component medical societies and specialty societies. I am firmly convinced that face-to-face discussions with members of the profession are mutually helpful to them and to the Plan in broadening the understanding of each other's problems . . . At the national level, I continued to enjoy the honor of serving as a Director of National Association of Blue Shield Plans and chairman of its Professional Relations Committee. This exposure to nationwide Blue Shield Plan operations has continued to reinforce my conviction that the New Jersey Blue Shield Plan is second to none in the nation because of the loyal support of its Participating Physicians.

*Comparative Balance Sheet, December 31, 1971*

<i>Assets</i>	<i>1971</i>	<i>1970</i>
Cash on Hand and in Banks (Working Funds)	\$ 2,188,910	\$ 1,935,753
Investments	30,776,162	24,836,258
Accounts Receivable—Subscriptions	1,744,293	1,422,409
Accounts Receivable—National Account Program	4,055,252	3,308,559
Accounts Receivable—Federal Employee Program	2,128,400	2,172,178
Accounts Receivable—Other	330,658	241,647
Accrued Interest and Dividends Receivable	436,559	330,228
Total Assets	<u>\$41,660,234</u>	<u>\$34,247,032</u>
<i>Liabilities</i>	<i>1971</i>	<i>1970</i>
Claims Outstanding:		
Reported	\$ 4,155,304	\$ 4,172,000
Unreported	13,413,000	13,553,000
National Accounts	<u>2,331,000</u>	<u>1,583,000</u>
Unearned Subscriptions	4,579,847	4,065,458
Accounts Payable—Miscellaneous	2,899,394	1,382,717
Reserve For Group Contract Settlements	1,856,588	2,998,222
Deposits From Other Organizations	973,656	972,512
Total Liabilities	<u>\$30,208,789</u>	<u>\$28,726,909</u>
<i>Reserves</i>	<i>1971</i>	<i>1970</i>
Securities Valuation	\$ 936,868	\$ 753,205
Special Contingent	100,000	100,000
Unassigned	10,414,577	4,666,918
Total Reserves	<u>\$11,451,445</u>	<u>\$ 5,520,123</u>
Total Liabilities and Reserves	<u>\$41,660,234</u>	<u>\$34,247,032</u>

## ANNUAL STATISTICS—1971

Table I  
Distribution of All Services and Payments

Paid 1971	Total Serv- ices	% All Serv- ices	Payment	Per Cent	Per Serv- ice
Surgical	781,575	36.2	\$38,005,555	47.4	\$ 48.63
Medical	1,096,794	50.8	26,000,076	32.4	23.71
Obstet- rical	45,729	2.1	8,626,512	10.7	188.64
Consulta- tions	65,246	3.0	1,362,427	1.7	20.88
Anesthe- sia	169,916	7.9	6,238,864	7.8	36.72
Total	2,159,260	100.0	\$80,233,434	100.0	\$ 37.16

Table II  
Distribution of Rider Services and Payments

Paid 1971	Total Serv- ices	% All Serv- ices	Payment	Per Cent	Per Serv- ices
Surgical	96,510	15.7	\$1,812,257	18.7	\$ 18.78
Medical	7,855	1.3	380,175	3.9	48.40
Diagnostic X-Ray	256,794	41.6	4,402,155	45.5	17.14
X-Ray Therapy	1,275	.2	206,501	2.1	161.96
Physical Therapy	15,187	2.5	356,808	3.7	23.49
Pathology	238,859	38.7	2,526,322	26.1	10.58
Total	616,480	100.0	\$9,684,218	100.0	\$ 15.71

Table III  
Distribution of Earned Subscription Income

Earned Subscription Income	\$100,103,130	100.0%
Incurred Claims	86,952,482	86.9%
Operating Expense	11,848,195	11.8%
Underwriting Gain	1,302,453	1.3%

## FEDERAL EMPLOYEE PROGRAM

Following is a statement of income and expense, along with utilization statistics of the 1971 experience of the Federal Employee Program.

Income	\$5,889,795	100.00%
Claims Incurred	5,585,061	94.83
	<u>\$ 304,734</u>	<u>5.17</u>
Operating Expense (Estimate)	447,000	7.59
(Loss)	<u>\$ (142,266)</u>	<u>(2.42%)</u>

*Paid Basis*

Average Exposure (Persons)	127,239
Services per 1,000 Persons Enrolled	633
Average Cost Per Service	\$ 64.19
Number of Services	80,513
Amount Paid	\$5,164,179

## CLAIMS INCURRED

Year	Incidence Per Thousand	Amount
1971	421	\$86,952,482
1970	401	80,369,777
1969	328	72,580,000
1968	304	58,536,000
1967	275	53,016,000
1963	193	40,991,000
1960	166	31,516,000
1957	143	22,886,000
1954	126	13,992,000
1951	112	6,527,000
1948	96	1,204,000
1945	86	208,000
1942	40	5,000

CIVILIAN HEALTH AND MEDICAL PROGRAM  
OF THE UNIFORMED SERVICES

Effective December 1, 1967, the Plan, with the approval of The Medical Society of New Jersey, was designated as contractor for the program, which on the same date adopted a usual and customary charges basis of payment, replacing the fixed fee schedule previously utilized.

Following is the experience for 1971:

Total Claims	Claims Received	Declined	Returned Incomplete
1971	25,567	3,240	5,157
	<i>Paid</i>		
Claims	Amount		On Hand
16,145	\$1,588,589		1766

## PUBLIC RELATIONS PROGRAM

Keeping physicians and subscribers informed as to plan programs, policies, and procedures represented the major thrust of Public Relations activities in 1971. This was carried out in a number of projects utilizing a variety of communications media.

*Literature.* A leaflet, "Conserving Your Health Care Dollar," describing the Plan's Utilization Review program and urging subscriber cooperation in proper utilization of benefits, was prepared and given wide distribution. It was mailed with direct payment subscriber bills, furnished to group enrollment officials for distribution to group sub-

scribers, and provided to physicians for placement in waiting rooms. Nearly a million copies were distributed—a half million within enrolled groups and about 200,000 via physicians' offices. Included in the advice to subscribers was "Don't ask your doctor to submit a claim for lab tests or x-rays performed as part of any routine health checkup." (This advice also was incorporated in a desk plaque that was furnished physicians to help them remind patients of the Plan's limitations on services under Rider J).

Another leaflet described the procedures to be followed in submitting claims for Blue Shield coverage complementing Medicare. This was provided to subscribers holding Medicare Complementary coverage, and to doctors for waiting room use.

*Newsletter.* The periodic newsletter for physicians and their office assistants carried pertinent information on fee schedule changes and other Blue Shield matters of current interest to the profession. Some of the topics covered during the year included use of current Service Reports; a description of the Board of Trustee's Physician Review Committee; instructions on using simplified Service Reports; requirement of a provisional diagnosis for lab and x-ray services; regulations governing the Federal Employee Program, and a description of the new Nursing Home and Home Care Program.

*News Releases.* Subscribers, and the general public as a whole, were informed through the press of the details of Plan programs such as "Medigroup" and Nursing Home and Home Care, and the over-all progress of the Plan during the year.

*Advertising.* Through advertisements in the medical press—the Journal of The Medical Society of New Jersey, the Journal of New Jersey Society of Osteopathic Physicians and Surgeons, and New Jersey Family Physician—the profession was informed from time to time of various development within the Plan. Advertisements in the general press stressed Blue

Shield's non-profit character, and the Plan's pre-eminence in the prepaid health care field.

*Public Service Programs.* The ongoing educational programs in the areas of drug abuse and alcoholism, demonstrating Blue Shield's concern with community health problems, continued to receive wide acceptance. Now in its third year, the drug abuse program included the distribution of over 47,000 copies of the Blue Shield booklet "Drug Abuse: The Chemical Cop-Out," bringing the total to about 200,000; the loan of three films on drug abuse of 26 institutions, organizations, and schools for a total of over 50 since the film became available; and the distribution of about 5,000 drug abuse posters to schools, colleges, business organizations, and individuals.

The alcoholism program included a booklet, "The Alcoholic American," and a two-part film for loan. Some 12,000 booklets were distributed, and films were loaned to about a dozen organizations, treatment centers, and individuals.

*Correspondence.* Correspondence concerning problems with subscribers' coverage, the basis and extent of Plan payments and similar matters were referred to the Public Relations Office by about two dozen newspapers, radio and TV stations. In the course of the year, 359 such inquiries were cleared, the vast majority by personal letter from the Public Relations Officer . . . Correspondence was drafted for several other areas of the Plan's operations for communicating with physicians and subscribers on general and specific topics.

It is felt that Public Relations communications in all types of media utilized served to increase the understanding of the Plan on the part of both physicians and subscribers.

#### PHYSICIAN RELATIONS PROGRAM

Throughout 1971, considerable effort by the Physician Relations Section was directed



toward the enrollment of doctors as Participating Physicians in the Plan's Basic and Prevailing Fee Programs. The successful results of this effort are reflected in the Annual Reports of N.J. Participating and Non-participating Physicians by Specialty and County (Basic and Prevailing Fee Program), which are included in this Annual Statement.

At year's end, the total number of Participating Physicians and Laboratories in the Basic Blue Shield Program stood at 8,238 or 79.6% of those eligible, a gain over 1970 of 365. In the Prevailing Fee Program, the number of Participating Physicians is 6,829 or 66.0%, a gain over 1970 of 595. Both of these totals represent an all-time high in number of participants.

We established and maintained communication between the Plan and the medical profession through our Field Program. During the year, Field Representatives made personal visits to the offices of 876 physicians—established information desks in the Physicians' Lounges of 96 hospitals throughout the State—addressed 5 hospital staff meetings—manned exhibits at 6 conventions—conducted 118 miscellaneous meetings such as emergency room groups, specialty society meetings, medical groups, etc.

In 1971, we continued to expand our program of developing a strong liaison between Blue Shield and the American Association of Medical Assistants, State of New Jersey, Inc. This program included sponsoring and addressing 4 district luncheon meetings—addressing 13 county society meetings—writing topical articles for their State publication "The Pulse" and assisting in its printing. We conducted 19 meetings at various technical schools, to train medical assistant students, including one ten-hour course on Blue Shield for the State Manpower Development Program. We also participated in their annual convention.

By means of a more active and diversified field program, we were able to hold 1,110 meetings for a total of 7,161 contacts in 1971.

This represents a 16.7% increase in field contacts over the preceding year.

We would like to take this opportunity to thank our Participating Physicians for their cooperation, loyalty and dedication.

#### UTILIZATION REVIEW PROGRAM

The Utilization Review Section makes reports to, and works closely with, the Physicians' Review Committee of the Board of Trustees, two-thirds of whose membership is composed of practicing physicians.

Utilization Review not only helps to conserve subscribers' funds; it also operates in the interest of the medical profession by helping to safeguard its reputation.

In 1971 the Utilization Review Program encompassed pre- and post-audits of claims including Basic Blue Shield, Federal, CHAMPUS, and Medicare Complementary Programs. All criteria for Utilization Review as required by the National Association of Blue Shield Plans were met.

#### *Effectiveness Of The Program*

Essentially, effectiveness of the program lies in the extent to which overuse and abuse is deterred. Widespread distribution of the leaflet "Conserving Your Health Care Dollar;" Flip Chart presentations, correspondence with physicians, and special meetings with physicians and medical assistants make it seem likely that most New Jersey physicians are now aware that New Jersey Blue Shield has an effective formalized Utilization Review Program.

#### *Flip Chart Presentation*

During the year 1971, the staff gave Flip Chart Presentations to the Utilization Committees and/or full staffs at 29 New Jersey hospitals. This brings the total to 69 presentations given since the inception of the program in 1969.

In addition to talks at hospitals, the New Jersey Medical Assistants were addressed at luncheon meetings of their North, Central and South Jersey Chapters.

Enrolled Groups requesting large quantities of "Conserving Your Health Care Dollar" were contacted for permission to give the Flip Chart talk to key personnel. Such presentations to subscribers stress the fact that Rider J does not cover diagnostic services in connection with annual physical examinations or checkups, but that such services must be for the diagnosis or treatment of a specific illness or injury.

#### ENROLLMENT REPORT

Total membership of Medical-Surgical Plan was increased in 1971 by 79,270 persons, representing a net gain of 2.3%. This was the result of the addition of 48,005 contracts during the 1971 marketing period. Current Plan membership of 3,493,548 persons represents 48.0% of the State's population.

Enrollment under the various Group programs totals 2,812,600 persons, an increase of 32,353 members over the 1970 year-end total. Members covered under the Basic Certificate, both with and without Rider coverage, total 1,390,218 persons, a decrease of 197,924. However, this decline in community group enrollment was offset by growth in the more specialized coverage categories.

An increase of 106,141 members in the governmental coverages was achieved, primarily as a result of the 36,269 contract addition to the State Municipal Program. The National Account category, including the New Jersey Bell and Western Electric Accounts, displayed a total membership increase of 47,327 members, bringing the total to 569,779.

Subscribers and dependents covered under Domestic Master Contracts totaled 227,268 at year end, an increase of 77,409 over the De-

cember 31, 1970 total. More than 54% of this gain was recorded in those Domestic Master Contracts which provided Prevailing Fee benefits to their members.

Enrollment with the Group Complementary coverage categories remained relatively stable throughout the year, at year end reporting a net decrease of only 600 members.

During 1971, the total number of groups enrolled increased by 396 to a total of 17,216.

The Direct Payment categories also displayed the same levels of growth as the Group classifications. Membership in the Left-Group segment grew by 15,396 persons, this increase being generated from additions to the Basic and Rider J category. Within the Non-Group segment a net gain of 19,712 members was registered. A total of 17,574 new members were enrolled under the Basic and Rider J classification, while under the Student program 2,138 new members were added. The senior citizen population enrolled under the Blue Cross and Blue Shield 65 program continued its growth during 1971 with 11,836 new members joining; of the 157,152 persons covered by the program, nearly 73% have also selected the Extended Benefits Rider to supplement this coverage.

With a renewed level of stability being forecast for the economy for the current year, it is anticipated that growth in 1972 will show improvement over the 1971 level reported.

#### ENROLLMENT GROWTH

1971	3,493,548
1970	3,414,278
1969	3,369,472
1967	2,908,799
1963	2,450,755
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

# COMPARATIVE SUMMARY OF OPERATIONS

	1971		1970	
Subscriptions Earned*	\$100,103,130	100.0%	\$86,927,856	100.0%
Less:				
Claims Incurred**	\$86,952,482	86.9	\$80,369,777	92.4
Operating Expenses***	<u>11,848,195</u>	<u>11.8</u>	<u>10,225,147</u>	<u>11.8</u>
	98,800,677	98.7%	90,594,925	104.2%
Gain or (Loss) from Underwriting Operations	\$ 1,302,453	1.3%	\$ (3,667,608)	(4.2%)
Income on Investments	<u>1,718,475</u>		<u>1,617,553</u>	
Operating Gain or (Loss) for the Year	\$ 3,020,928		\$ (2,949,515)	

\*The gain of \$13,175,274 in subscriptions earned reflects gain in enrollment, which increased by 79,270 during the year, and a rate increase effective February 1, 1971.

\*\*The rise of \$6,582,705 in claims incurred is attributable to increased exposure from larger enrollment, and to increased incidence, which rose from 401 per 1,000 persons to 421.

\*\*\*The increase of \$1,623,048 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of \$1,098,096 and an increase of \$524,952 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, the percentage of total operating expense remained unchanged.

## SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

	1971	1970
Reserves at January 1	\$ 5,520,123	\$8,582,412
Operating Gain or (Loss) for the Year	<u>3,020,928</u>	<u>(2,049,515)</u>
	\$ 8,541,051	\$6,532,897
Plus: Reserve Adjustments		
Non-Admitted Assets	\$ 420,173	\$ (574,230)
Unrealized Capital Gains	196,288	60,368
Adjustment of Prior Year's Income	247,431	(539,000)
Claim Reserve	916,000	242,000
Distribution of Prior Year's Income	<u>1,130,502</u>	<u>322,400</u>
Group Contract Settlement	2,910,394	(524,312)
		<u>(1,012,774)</u>
Reserves at December 31	\$11,451,445	\$5,520,123



New Jersey Participating and Non-Participating Physicians by County—Basic Program

County	Total Elig. Phys.	PARTICIPATING				NON-PARTICIPATING				% P.P. as of			
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	12-31-71	12-31-70
Atlantic	277	272	237	15	15	5	5	4	1	3	1	98.1	96.5
Bergen	1269	768	641	76	34	17	510	488	9			60.5	59.7
Burlington	302	277	218	45	12	2	25	23	2			91.7	91.1
Camden	791	692	462	187	35	8	99	91	6	2		87.4	87.0
Cape May	68	64	48	11	3	2	4	2	2			94.1	90.7
Cumberland	142	134	115	9	7	3	8	7	1			94.3	94.7
Essex	1743	1416	1287	48	65	16	327	318	4	2	3	81.2	80.7
Gloucester	167	146	102	32	9	3	21	19	2			87.4	87.7
Hudson	747	624	567	15	35	7	123	118	2	2	1	83.5	83.3
Hunterdon	73	67	67				6	6				91.7	92.7
Mercer	546	452	413	15	19	5	94	91	3			82.7	83.4
Middlesex	598	453	410	19	14	10	145	140		2	3	75.7	76.3
Monmouth	587	433	400	16	14	3	154	147	5	2		73.7	73.9
Morris	531	438	391	28	11	8	93	87	4	1	1	82.4	81.6
Ocean	221	162	138	17	6	1	59	55	2	1	1	73.3	71.7
Passaic	684	508	445	31	27	5	176	171	2	2	1	74.2	73.4
Salem	54	50	41	6	2	1	4	3	1			92.6	92.7
Somerset	251	215	202	6	6	1	36	33	1	1	1	85.6	83.6
Sussex	75	71	61	6	1		4	4				94.6	92.8
Union	885	681	570	62	41	8	204	200	3	1		76.9	76.3
Warren	58	55	49	3		3	3	3				94.8	94.1
Out of State	274	260	222	33	4	1	14	14				94.9	91.2
Total	10343	8238	7089	680	360	109	2105	2024	50	19	12	79.6	79.0

New Jersey Participating and Non-Participating Physicians by Specialty—Basic Program

Ancs.	453	238	220	18		215	209	6		52.5	50.3
Derm. Syph.	175	122	122			53	53			71.8	
Int. Med.	1554	1197	1158	39		357	357			77.0	76.9
Neur. Surg.	79	56	56			23	23			70.8	60.5
Obst. Gyn.	800	620	604	16		180	177	3		77.5	74.3
Ophth.	345	227	223	4		118	118			65.7	66.6
Orth. Surg.	348	227	219	8		121	121			65.2	65.0
Otol.	218	151	144	7		67	66	1		69.2	66.1
Path.	199	168	163	5		31	30	1		84.4	82.3
Ped.	584	520	515	5		64	64			89.0	88.3
Phys. Med.	26	22	21	1		4	4			84.6	84.0
Plast. Surg.	48	21	20	1		27	27			43.7	35.5
Anal. Labs	121	109			109				12	90.1	90.2
Proct.	40	20	12	8		20	20			50.0	57.5
Psy. & Neuro.	512	360	354	6		152	152			70.3	69.6
Radiology	318	256	246	10		62	62			80.5	77.8
Surg.	997	775	749	26		222	222			77.7	77.2
Thor. Surg	51	37	37			14	14			72.5	71.7
Urol.	234	129	128	1		105	105			55.1	54.2
Podiatry	379	360			360	19		19		94.9	94.6
General	2862	2623	2098	525		239	200	39		91.6	91.1
Total	10343	8238	7089	680	360	109	2105	50	19	79.6	79.0

New Jersey Participating and Non-Participating Physicians by County—Prevailing Fee

County	Total Elig. Phys.	PARTICIPATING				NON-PARTICIPATING				Lab.	% P.P. as of	
		Total	M.D.	D.O.	D.P.M.	Total	M.D.	D.O.	D.P.M.		12-31-71	12-31-70
Atlantic	277	229	202	12	11	48	39	4	4	1	82.6	79.5
Bergen	1269	646	542	63	28	623	587	22	9	5	50.9	48.5
Burlington	302	295	182	42	9	67	59	5	3		70.2	70.2
Camden	791	576	385	155	29	215	168	38	8	1	72.8	69.0
Cape May	68	46	36	7	3	22	11	6		2	67.6	66.1
Cumberland	142	115	100	6	6	27	22	4	1		80.9	78.9
Essex	1753	1192	1091	39	50	551	514	13	17	7	67.9	65.0
Gloucester	167	120	81	28	9	47	40	6		1	71.8	67.7
Hudson	747	526	477	14	30	221	208	3	7	3	70.4	67.3
Hunterdon	73	57	57			16	16				78.0	69.5
Mercer	546	401	368	13	16	145	136	5	3	1	73.4	70.4
Middlesex	598	386	349	17	12	212	201	2	4	5	64.5	61.1
Mounmouth	587	373	347	13	11	214	200	8	5	1	63.5	60.9
Morris	531	364	323	25	10	167	155	7	2	3	68.5	65.8
Ocean	221	114	99	11	4	107	94	8	3	2	51.5	46.6
Passaic	681	437	386	27	21	247	230	6	8	3	63.8	60.5
Salem	51	41	36	5	2	10	8	2			81.4	76.3
Somerset	251	173	161	5	6	78	74	2	1	1	68.9	68.1
Sussex	75	62	55	6	1	13	13				82.6	70.0
Union	885	547	454	53	34	338	316	12	8	2	61.8	58.4
Warren	58	50	45	2		8	7	1			86.2	86.2
Ont of State	271	136	115	18	3	138	121	15	1	1	49.6	43.7
Total	10343	6829	5891	561	295	3514	3222	169	84	39	66.0	62.6

New Jersey Participating and Non-Participating Physicians by Specialty—Prevailing Fee

Specialty	Total Elig. Phys.	PARTICIPATING				NON-PARTICIPATING				Lab.	% P.P. as of	
		Total	M.D.	D.O.	D.P.M.	Total	M.D.	D.O.	D.P.M.		12-31-71	12-31-70
Anes.	453	262	245	17		191	184	7			57.8	16.8
Derm. Syph.	175	104	104			71	71				59.4	56.8
Int. Med.	1554	1032	991	31		532	524	8			65.7	63.9
Neur. Surg.	79	47	47			32	32				59.4	49.2
Obst. Gyn.	809	564	551	13		236	230	6			70.5	66.4
Ophth.	345	203	201	2		142	140	2			58.8	53.9
Orth. Surg.	348	175	167	8		173	173				50.3	48.0
Otol.	218	120	126	6		92	90	2			57.7	55.0
Path.	199	112	110	2		87	83	4			56.2	47.6
Ped.	584	403	398	5		181	181				69.0	66.1
Phys. Med.	26	16	15	1		10	10				61.5	52.0
Plast. Surg.	48	12	11	1		36	36				25.0	20.0
Anal. Labs.	121	82				39	39			39	67.7	60.9
Proct.	40	27	21	6		13	11	2			67.5	62.5
Psy. & Neuro.	512	324	319	5		188	187	1			63.2	58.7
Radiology	318	200	191	9		118	117	1			62.8	62.1
Surg.	997	657	633	24		340	338	2			65.8	63.5
Thor. Surg.	51	29	29			22	22				56.8	53.0
Urol.	234	132	131	1		102	102				56.4	54.2
Podiatry	379	295			295	84			84		77.8	75.7
General	2862	2037	1607	430		825	691	134		39	71.1	67.4
Total	10343	6829	5891	561	295	3514	3222	169	84	39	66.0	62.6

## OFFICERS

Thomas J. White, M.D., Chairman of the Board

Joseph P. Donnelly, M.D., President

John S. Robinson  
Executive Vice President  
and Secretary-Treasurer

Francis J. Novak, Vice-President—Operations

Jerome C. Rothgesser, M.D.  
Vice President—Medical Affairs  
and Medical Director

## BOARD OF TRUSTEES

*Chairman of the Board*

Thomas J. White, M.D. (1974)

*First Vice President*

Rudolph C. Schretzmann, M.D. (1974)

Donald T. Akey, M.D. (1972)  
Edwin H. Albano, M.D. (1974)  
Robert G. Boyd (1972)  
Joseph A. Cox, M.D. (1972)  
James T. Crowley (1974)  
Charles L. Cunniff, M.D. (1972)  
E. Vernon Davis, M.D. (1972)  
Andrew P. Dedick, Jr., M.D. (1972)  
Edgar P. Eaton, Jr. (1973)

Lloyd M. Felmlly (1974)  
\*Edwin T. Ferren, D.O. (1973)  
Mortimer J. Fox, Jr. (1973)  
\*Jerome G. Kaufman, M.D. (1973)  
John Kelley (1974)  
Samuel J. Lloyd, M.D. (1974)  
Theron L. Marsh (1974)  
\*Jesse McCall, M.D. (1974)  
Earl R. Mellen (1972)

*Second Vice President*

Joseph M. Keating, M.D. (1973)

Henry J. Mineur, M.D., (1973)  
Warren H. Simmons, Jr. (1972)  
Sidney I. Simon, Ph.D. (1972)  
Morgan Sweeney (1972)  
Charles O. Tyler, M.D. (1974)  
Stanley C. Van Ness, Esq. (1973)  
Robert E. Verdon, M.D. (1972)  
John F. Waters (1973)

## TRUSTEES EMERITUS

	<i>Appointed</i>	<i>Term as Board Member</i>
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
Edward W. Sprague, M.D.	1966	1942-1966
John S. Thompson	1966	1942-1965

## ADVISORS TO THE BOARD OF TRUSTEES

	<i>Appointed</i>	<i>Term as Board Member</i>
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952

## FORMER MEMBERS OF THE BOARD OF TRUSTEES

*David B. Allman, M.D. 1945-1945	*Samuel A. Cosgrove, M.D. 1944-1953	Glenn S. Rickert, M.D. 1959-1963
*Charles W. Barkhorn, M.D. 1952-1965	Joseph P. Donnelly, M.D. 1953-1968	*Royal A. Schaaf, M.D. 1942-1964
Irving P. Borsher, M.D. 1950-1965	*William K. Harryman, M.D. 1944-1945	*Norman M. Scott, M.D. 1942-1950
*F. Clyde Bowers, M.D. 1961-1963	Sigurd W. Johnsen, M.D. 1942-1948	*Reuben L. Sharp, M.D. 1950-1952
*Theophilus H. Boysen, M.D. 1944-1945	*Augustus S. Knight, M.D. 1942-1948	James J. Spencer, M.D. 1957-1961
Lewis W. Brown, M.D. 1949-1954	*Thomas K. Lewis, M.D. 1942-1949	Gustave E. Wiëdenmayer 1961-1966
*William J. Carrington, M.D. 1942-1943	*Arthur W. Lunn 1951-1962	*Carl K. Withers 1952-1961
*Harry N. Comando, M.D. 1942-1958	Paul Mecray, Jr., M.D. 1953-1961	David L. Yunich 1962-1963
	Duane E. Minard, Jr. 1957-1965	

\*Deceased

Approved with recommendations (page Tr 131)



# College of Medicine and Dentistry of New Jersey

Stanley S. Bergen, Jr., M.D., President

(The following report was received by the House without reference to committee.)

I am pleased to have this opportunity to report briefly to you on progress at the College of Medicine and Dentistry of New Jersey and also to thank you for the support you have given the College during the past year.

We are especially grateful for your leadership in securing the passage of the higher education bond issue last November. Your help was one of the critical elements in the achievement of this important legislation.

Tangible progress is being made thanks to passage of the bond issue. In July we broke ground and started construction of the Newark campus which will include the following: dental and medical schools, a library, a teaching hospital, and a community mental health center.

The powerplant is taking shape. If you have a chance to drive by the site between South Orange Avenue and 12th at Norfolk Street, you will see the steel superstructure of the building silhouetted against the downtown Newark skyline.

In the past few months additional construction contracts have been awarded. Work has started on the future home of the New Jersey Dental School—currently housed in Jersey City—and the library. The contract for construction of the New Jersey Medical School basic science building was awarded this week. Plans are being completed for the community mental health center and teaching hospital with contracts to be awarded as quickly as possible. At this time about \$70 million in contracts have been awarded.

When completed the Newark campus will house approximately 375 dental, 700-800 medical, and up to 50 graduate students in the biomedical sciences. Available to them will be a library of 125,000 volumes and one

of the most advanced teaching hospitals in the nation.

When our present construction programs are completed and classes expand to achieve maximum use of the space available, the College will be able to graduate 200 medical, 125 dental, and up to 50 graduate students in the school of biomedical sciences annually.

Affiliates of the New Jersey Medical School include: Beth Israel Medical Center, East Orange Veterans Administration Hospital, St. Michael's Hospital, and United Hospitals in Newark, and Jersey City Medical Center in Jersey City.

Rapid progress is being made in the college's program to achieve one of its top priority goals—a four-year medical program at the Rutgers Medical School. If plans are completed as intended, this will be a reality in September of this year when the first students to enter their clinical years at the school will begin study at either the school's primary teaching hospital, Raritan Valley Hospital, Greenbrook, or at one of its affiliates—Hunterdon Medical Center, Flemington, Medical Center at Princeton, Muhlenberg Hospital in Plainfield, or Middlesex Hospital, New Brunswick.

At Raritan Valley Hospital we are currently engaged in a \$4.2 million renovation program, the goal of which is to provide needed facilities for the Rutgers Medical School clinical education programs.

A key element in achievement of our Rutgers program goal has been the highly important affiliations with community hospitals. Eventually the Rutgers School will have a teaching hospital at the Piscataway campus where very specialized programs will be carried out, but the real root of the school will always remain

in the community hospitals where many of our graduates will eventually intern and hopefully practice.

It should be noted that of those students who have been awarded doctoral degrees since the founding of the College nearly 25 per cent are in practice as either physicians or dentists in the State of New Jersey today. Most of the other are fulfilling armed forces obligations or are in intern or resident training.

The New Jersey Medical School has continued its evaluation of the possibility of offering a three-year doctor of medicine program. In December 1971, 12 students in a pilot class received their doctor of medicine degrees at special ceremonies in Newark. However, it is felt that additional evaluation must be made before any long-term program is implemented. I should note here that the New Jersey Dental School has successfully achieved its three-year program and that its first trimester class of 52 graduated in March 1972. Another class will graduate in December at which time the slack will be taken up and all future classes will be working on a three-year schedule.

On Saturday and Sunday, representatives of the four schools of the College will be present at our booth in the exhibit hall to answer any questions you have about the College, its schools, and programs. Factual details about the College and its schools are listed in the adjacent column.

As you know, we have joined with your Society and other health care delivery professionals in the state to develop statewide programs concerned with improving the quality of health care delivery in New Jersey. We are deeply grateful for the opportunity to share with you in this important work.

The College, its faculty, administration and students join me in wishing your Society success in the future. We look forward to our continuing association in behalf of the health of all New Jerseyans.

#### College Officers

Dr. Stanley S. Bergen, Jr., President  
Dr. Charles Vevier, Executive Vice President  
John Kervick, Vice President, Financial Affairs  
Herbert M. Groce, Jr., Vice President, Human Resources  
Richard Durbin, Vice President, Planning and Development  
Kenneth Dwyer, Registrar

#### Student Enrollment 1971-72

New Jersey Medical School	393
New Jersey Dental School	227
Rutgers Medical School	161
Graduate School of Biomedical Sciences	21
Total	802

#### Student Distribution

County	NJMS	NJDS	RMS
Atlantic	5	1	2
Bergen	54	22	19
Burlington	1	1	4
Camden	8	1	3
Cape May	0	0	0
Cumberland	1	2	4
Essex	127	39	13
Gloucester	2	0	2
Hudson	32	47	7
Hunterdon	1	1	0
Mercer	9	1	9
Middlesex	22	16	15
Monmouth	13	5	5
Morris	14	2	5
Ocean	2	5	2
Passaic	21	10	7
Salem	0	0	0
Somerset	2	2	5
Sussex	1	0	1
Union	38	19	12
Warren	0	0	1
Total	353	174	116

#### Alumni Distribution

Over 25 per cent of our 1356 graduates are engaged in medical and dental practice in New Jersey. Remaining graduates are either in intern or resident training or fulfilling service obligations in the armed forces or public health service.

#### College Faculty

	Total	Full Time	Part Time
New Jersey Medical School*	954	300	654
New Jersey Dental School	160	49	111
Rutgers Medical School	96	81	15
Total	1210	430	780

#### College Primary Teaching Hospitals

	Physicians	Nurses	Support Staff	Volunteers	Beds
Martland Hospital	210†	242	1816	60	625
Raritan Valley Hospital	132	96	308	440**	125
Total	342	338	2124	500	750

\*Includes Graduate School of Biomedical Science

†House Staff: Residents and Interns

\*\*Includes In-Service and Out-Service

# Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1972 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

## Burlington County

Edwin A. Harris, M.D., Easton, Md. (formerly Moorestown), Age 74  
Robert W. Elwell, M.D., Delanco; Age 52

## Cumberland County

Leslie E. Myatt, M.D., Bridgeton; Age 78  
Charles Butcher, M.D., Heislerville; Age 88

## Essex County

Maclyn F. Baker, M.D., Palm Beach, Fla. (formerly Irvington); Age 74  
Arthur E. Cameron, M.D., Newark; Age 82  
Felix J. DiFino, M.D., Newark; Age 66  
Joseph Gamba, M.D., Newark; Age 65  
John H. Hermann, M.D., Delray Beach, Fla. (formerly Orange); Age 81  
Charles E. Kiessling, M.D., New Shrewsbury; Age 66  
Clymont A. MacArthur, M.D., Newark; Age 78  
Thomas J. Ormsby, M.D., New York, N. Y. (formerly Newark); Age 66  
James R. Rampond, M.D., East Orange; Age 71  
Harry Schreck, M.D., Maplewood; Age 69

## Hudson County

Solomon Hirsch, M.D., Jersey City, Age 67  
Frank Marshall, M.D., Weehawken; Age 66  
Williams J. Mulvihill, M.D., Lakewood; Age 66  
Anthony T. Stokes, M.D., Secaucus; Age 63

## Mercer County

Charles M. Franklin, M.D., Princeton; Age 61  
Joseph R. Pierson, M.D., Jamesburg; Age 70  
Peter J. Warter, M.D., Surf City; Age 69

## Middlesex County

Howard E. Dieker, M.D., Lakewood; Age 66  
Gerard R. Gessner, M.D., Rockville, Md. (formerly New Brunswick); Age 62  
Fannie Sender, M.D., Rumson; Age 71  
William D. Van Riper, M.D., Green Pond; Age 62

## Morris County

Ruth Ferriss, M.D., Morristown; Age 70

## Ocean County

L. Roberto Carmona, M.D., Tuckerton; Age 75  
Ruth M. Schriever, M.D., Normandy Beach; Age 64  
Raymond A. Taylor, M.D., Toms River; Age 67  
Leo J. Ward, M.D., Point Pleasant; Age 77

## Passaic County

George L. Becker, M.D., Fort Lauderdale, Fla. (formerly Paterson); Age 70  
Joseph J. Bono, M.D., Clifton; Age 70  
Sidney H. Joffe, M.D., Naples, Fla. (formerly Paterson); Age 63

## Somerset County

Eva R. Sargent, M.D., North Plainfield; Age 63

## Union County

Richard S. Battaglia, M.D., Elizabeth; Age 57  
John S. Denholm, M.D., Daytona Beach, Fla. (formerly Westfield); Age 64  
Joseph E. Franklin, M.D., Juno Beach, Fla. (formerly Hillside); Age 68  
Fletcher Gilpin, M.D., Cranford; Age 64  
Benjamin E. Glass, M.D., Watchung; Age 72  
Herman H. Goldstein, M.D., Elizabeth; Age 67



Ross J. Maggio, M.D., Lakewood; Age 66  
 George H. Marts, M.D., Boca Raton, Fla.  
 (formerly Plainfield); Age 65  
 Karl E. Morris, M.D., Westfield; Age 65  
 Edwin J. O'Brien, M.D., St. Largo, Fla.  
 (formerly Plainfield); Age 58  
 Harris H. Palmer, M.D., Westfield; Age 64  
 Richard C. Peters, M.D., Sandwich, Mass.  
 (formerly Plainfield); Age 68  
 Joseph R. Schenk, M.D., Plainfield; Age 68  
 Leslie M. Townsend, M.D., Morris, Conn.  
 (formerly Roselle Park); Age 65  
 William W. Widdowson, M.D., Summit; Age  
 65  
 Ralph A. Young, M.D., Maplewood; Age 65

Approved (page Tr 142)

## Supplemental Report

The following additional nominations for election to emeritus membership have been received:

### *Essex County*

Henry Briggs, M.D., Ft. Lauderdale, Fla.  
 (formerly E. Orange); Age 77  
 Abraham L. Dear, M.D., West Orange; Age 62  
 William M. Epstein, M.D., Roselle Park; Age  
 65  
 Carl A. Nacca, M.D., Clifton; Age 66  
 Joseph J. Olini, M.D., Madison; Age 77  
 John R. Pavia, M.D., Livingston; Age 66  
 Arthur E. Sherman, M.D., Chatham; Age 68

Approved (page Tr 142)

Incoming President William J. D'Elia, Mrs. D'Elia, their sons, daughter, and granddaughters.





Incoming President D'Elia receiving Presidential Plaque and Certificate from President Davis.



(Right) President-Elect Matthew E. Boylan.



Reception honoring Incoming President D'Elia.

---

# MEMORIAL RESOLUTIONS

---

The following resolutions were received by the House with sorrowful concurrence.

## Jerome George Kaufman, M.D. (1901-1972)

Whereas, after a rich life of distinguished and exemplary service as a renowned physician and outstanding medical leader, Jerome George Kaufman, M.D., our beloved colleague, has been called to his eternal reward; and

Whereas, as President, member of the Board of Trustees, Chairman of the Committee on Annual Meeting, member of numerous councils and committees, and Delegate to the American Medical Association, Doctor Kaufman uniformly rendered high and valuable services to The Medical Society of New Jersey and to the people of our State; and

Whereas, his generous spirit led him to give further of himself as member and President of the State Board of Medical Examiners and as an active worker in many spheres of com-

munity and governmental health-care concerns; and

Whereas, by his indefatigable industry he commanded esteem and by his quiet amiability he won the affections of all with whom he came in contact; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring Jerome George Kaufman, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow in token of heartfelt sympathy.

## Jesse McCall, M.D. (1906-1972)

Whereas, Almighty God, in His inscrutable wisdom has summoned our beloved and esteemed colleague, Jesse McCall, M.D.; and

Whereas, in his long years as a member, Doctor McCall consistently rendered splendid service to The Medical Society of New Jersey, as President, Treasurer, Trustee, Chairman of the Council on Legislation, and Speaker of the House of Delegates—to name but a few of the offices which he graced; and

Whereas, in his almost two-score years of practice he always exemplified the attributes of a true humanitarian and distinguished physician; and

Whereas, by his gentle graciousness and undeviating devotion to the highest ideals of mankind and the profession of medicine, he ever encouraged and inspired those with whom he came into contact; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to Doctor McCall's bereaved widow and family in token of heartfelt sympathy.



---

# RESOLUTIONS

---

## #1

### Election of AMA Delegates

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, the American Medical Association is the ultimate policy-making organization for physicians; and

Whereas, in order for the American Medical Association to represent its member-physicians, the delegates to the American Medical Association must be representative of the local societies; and

Whereas, under current procedures relatively few ever are able to serve as American Medical Association delegates; now therefore be it

RESOLVED, that the elected delegates to the American Medical Association from The Medical Society of New Jersey shall not serve more than three successive terms; and be it further

RESOLVED, that the election of these delegates shall take place within the Judicial District from which they serve, rather than in the House of Delegates of The Medical Society of New Jersey.

Adopted as amended by deletion of second "resolved" and the words "and be it further" in the first "resolved" (page Tr 1271

## #2

### Liberalization of Abortion Laws

Arnold M. Kallen, M.D., Delegate from Essex County

(Reference Committee "A")

Whereas, the United States District Court has declared the law of the State of New Jersey affecting abortion to be unconstitutional, vague, and violating a woman's right to privacy; and

Whereas, it is a statistical fact that abortions have been, and will continue to be, performed in a clandestine manner with serious medical risks to the women involved; and

Whereas, the only other alternative available to women of New Jersey is to go out-of-state to unfamiliar physicians and locations to have performed abortions on themselves; and

Whereas, women express the right to determine for themselves when they shall carry through pregnancies to delivery; and

Whereas, growing societal concerns regarding overpopulation and its consequent depletion of natural resources, pollution of the natural environment, and its strains on societal institutions and services; and

Whereas, the present trend in societal attitudes is toward allowing abortions to be done more readily; and

Whereas, medical knowledge and skills have

reached a level where very high safety for the patient regularly exists; and

Whereas, the physicians licensed in the State of New Jersey have the responsibility of providing proper medical services to their patients; and

Whereas, under the existing law of New Jersey, licensed physicians are unfairly exposed to the possibility of prosecution for performing an abortion; now therefore be it

RESOLVED, that The Medical Society of New Jersey strongly urge the Legislature of the State of New Jersey to draft and pass more pertinent and generously applicable abortion laws, that include these necessary features:

- (a) There be no restriction to the performance of abortion up to the end of the 24th week from commencement of pregnancy, except those of good, safe, medical practice.
- (b) That the only requirement for the performance of abortion be that the pregnant woman gives her consent, and that her physician agrees her health would safely permit it or states that her physical or mental health requires it.
- (c) A pregnant woman, age 16, but under 21, should not be required to obtain parental or guardian consent for abortion.
- (d) Pregnant girls under age 16 should have parental or guardian consent, if available, for abortion, but if this consent is not obtainable, a written concurring opinion by another licensed physician should be considered adequate, with no right to later retraction.
- (e) Abortions should be performed only in such areas of hospitals where adequate surgical practice can be assured by competent medical personnel.

(f) No physician shall be required to perform an abortion nor shall any institution be required to allow an abortion to be performed within its walls.

(g) No physician or medical institution can be declared liable for having performed an abortion provided written permission was obtained from the pregnant woman, and the procedure was done according to the usual proper, accepted standards of good medical care.

Not Adopted (page Tr 127)

Reference Committee offered the following substitute resolution for Resolution #2: Substitute Resolution Adopted (For: 147; Against: 122) (page Tr 127)

Substitute Resolution for Resolution #2  
Liberalization of Abortion Laws

Whereas, the United States District Court has declared the law of the State of New Jersey affecting abortion to be unconstitutional, vague, and violating a woman's right to privacy; and

Whereas, it is a statistical fact that abortions have been, and will continue to be, performed in a clandestine manner with serious medical risks to the women involved; and

Whereas, the only other alternatives available to women of New Jersey are: (1) to go out-of-state to unfamiliar physicians and locations to have abortions performed; (2) to have illegal abortions performed under less than optimal conditions; or (3) to bear an unwanted child; and

Whereas, women express the desire to have the right to determine for themselves when they shall carry through pregnancies to delivery; and

Whereas, there are growing societal concerns regarding overpopulation and its consequent depletion of natural resources, pollution of the natural environment and its strains on societal institutions and services; and

Whereas, medical knowledge and skills have reached a level where very high safety for the patient regularly exists when performed under optimal conditions in a hospital environment; and

Whereas, the physicians licensed in the State of New Jersey have the responsibility of providing proper medical services to their patients; and

Whereas, under the existing law of New Jersey have the responsibility of providing proper medical services to their patients; and

Whereas, under the existing law of New Jersey, licensed physicians are exposed to the possibility of prosecution for performing abortions; now therefore be it

RESOLVED, that The Medical Society of New Jersey strongly urge the Legislature of the State of New Jersey to draft and pass more pertinent and applicable abortion laws that include the following guidelines:

(a) There be no restriction upon the performance of abortion up to the end of the 16th week from commencement of pregnancy, except those of good, safe, medical practice.

(b) That the requirements for the performance of abortion be: (1) that the pregnant woman gives her consent; (2) that, if married, her husband either concur, or sign a release; (3) that her physician agree that her health would safely permit it, or state that her physical or mental health requires it.

(c) A pregnant woman, age 18 or over, should not be required to obtain parental or guardian consent for abortion.

(d) Pregnant girls under age 18 should have parental or guardian consent for abortion.

(e) Abortions should be performed only in those areas of hospitals where adequate surgical practice can be assured by competent medical personnel.

(f) No physician shall be required to perform an abortion, nor shall any institution be required to allow an abortion to be performed within its walls.

(g) No physician or medical institution can be declared liable for having performed an abortion provided that appropriate written permission was obtained and the procedure was done according to accepted standards.

(h) No abortion shall be permitted in New Jersey on any woman who is not a bona fide resident of the state.

(i) No advertising or solicitation of patients for abortions, by direct or indirect methods, in or outside the State of New Jersey, shall be permitted.

### #3

## MSNJ Membership for Interns and Residents

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the AMA provides for interns and residents to be members of the AMA if they are serving in training programs approved by the AMA; and

Whereas, interns and residents may enter into AMA membership through active membership in a state and component medical society, or by direct application to the AMA where there are no provisions for active membership in their state medical society; and

Whereas, it is most desirable to bring young M.D.'s into organized medicine through membership in county and state societies; and

Whereas, medical societies in other states have had outstanding success in bringing interns and residents into their societies; and

Amended by Reference Committee by deletion of above  
whereas (page Tr 129)

Whereas, all interns and many residents do not have a license to practice medicine in New Jersey and therefore are ineligible for membership in The Medical Society of New Jersey and its component societies; now therefore be it

RESOLVED, that this House of Delegates approve the establishment of an active membership category in The Medical Society of



New Jersey for interns and residents; and be it further

RESOLVED, that this House of Delegates instruct the Committee on Revision of Constitution and Bylaws to prepare and submit to the House of Delegates, at its next annual meeting, proposed changes in the Constitution and Bylaws of this Society which will establish an active membership category for interns and residents in MSNJ and which will permit component societies to establish such a membership category if they choose to do so.

Foregoing RESOLVEDS amended by deletion of "an active" before "membership category" in both RESOLVEDS, to read:

RESOLVED, that this House of Delegates approve the establishment of a membership category in The Medical Society of New Jersey for interns and residents; and be it further

RESOLVED, that this House of Delegates instruct the Committee on Revision of Constitution and Bylaws to prepare and submit to the House of Delegates, at its next annual meeting, proposed changes in the Constitution and Bylaws of this Society which will establish a membership category for interns and residents in MSNJ and which will permit component societies to establish such a membership category if they choose to do so.

Adopted as amended by the Reference Committee (page Tr 129)

## #4

### Nominating Procedure

From the Bergen County Medical Society  
(Reference Committee "A")

Whereas, the Nominating Committee is one of the most vital committees of the Society; and

Whereas, under current usages, nomination for office by this Committee virtually assures election; and

Whereas, the Nominating Committee does not always have full knowledge of the candidates' ability and performance; and

Whereas, the House of Delegates is expected to ratify the Nominating Committee's report also without full knowledge of the candidates; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey require the following:

(1) All candidates for elective office and delegates to the AMA be identified not later than 31 March of any fiscal year.

(2) The names of these candidates and their resumes be included in the House of Delegates Convention Manual.

(3) No member of the Nominating Committee shall serve more than three consecutive years.

(4) The Committee on Revision of Constitution and Bylaws shall be instructed to study the nominating and election procedure with a view toward achieving maximal involvement of our membership, and report its recommendations at the next annual meeting of the House of Delegates.

Not Adopted—Referred to Board of Trustees with the request that the Board establish an ad hoc committee to investigate the matter and report to the House of Delegates at the 207th Annual Meeting (page Tr 129)

## #5

### Prompt Transmittal of Information to Component Societies

From the Hudson County Medical Society

(Reference Committee "A")

Whereas, during the past year it has become apparent on a number of occasions that information of importance to the county medical societies has not been forwarded by The Medical Society of New Jersey to the component society offices—an example of this is the involvement with Comprehensive Health Planning, in which MSNJ did not give any information or guidance to the component societies in this important area; and

societies that there are probably more areas of this nature that require closer communication between the county and State societies; now therefore be it

RESOLVED, that all matters of importance to the component societies that become known to MSNJ be brought to the attention of the component societies, as quickly as possible, and guidance and assistance offered as requested.

Whereas, it is the feeling of the component

Not Adopted (page Tr 129)

## #6

### Survey of Methods to Increase AMA Membership

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, membership and participation in the American Medical Association have declined; and

Whereas, this must reflect a rejection of some features of the organization; and

Whereas, it is essential that the medical profession be properly organized and represented; and

Whereas, the American Medical Association has the most logical mechanism for this purpose; now therefore be it

RESOLVED, that all component societies be required to:

- (1) Review existing circumstances in their immediate area which have bearing on the problem;

- (2) Make recommendations for revision of conditions that are possibly contributory;

- (3) Through polling their membership, advance proposals for new mechanisms or activities that will revitalize interest;

- (4) Report to the State Society within six months the results of these inquiries.

The State Society shall collate and assemble these reports and publish the results in *The Journal* of MSNJ within three months thereafter so that resolutions regarding them can be submitted to the House of Delegates at the 1973 Annual Meeting.

Adopted (page Tr 129)

## #7

### Avoidance of Conflicts of Interest

From the Union County Medical Society

(Reference Committee "C")

Whereas, an increasing number of physicians are associated with insurance companies and other third-party carriers as paid officers, employees and/or members of their boards of trustees; and

Whereas, many of the physicians in this category may serve as officers, delegates and members, and/or chairmen of important committees within the framework of The Medical Society of New Jersey; and

Whereas, a conflict of interest may arise when such physician-employees are faced with policy decisions and actions of the third-party carrier which affect and regulate the private

practice of physician-members of The Medical Society of New Jersey and component medical societies; now therefore be it

RESOLVED, that when a physician-member who is an officer, delegate, committee member, and/or chairman within the framework of The Medical Society of New Jersey or a component medical society and simultaneously serves as an officer, paid employee, or a member of the board of trustees of an insurance or third-party carrier, he meticulously evaluate his position with such agencies with a view to precisely identifying and resolving actual or potential conflicts of interest.

Not Adopted (page Tr 132)

## #8

### Discontinuance of Practice of Clearing Nominations for MSP Board Through MSNJ

From the Union County Medical Society

(Reference Committee "C")

Whereas, alterations in the enabling act no longer make it mandatory that 50 per cent of the Board of Trustees of Blue Shield of New Jersey be members of The Medical Society of New Jersey; and

Whereas, nominations for the positions on the Board of Trustees of Blue Shield of New Jersey are made by a nominating committee of that organization alone; and

Whereas, the Constitution of The Medical So-

ciety of New Jersey does not stipulate that its Board of Trustees and House of Delegates must act on such nominations; now therefore be it

RESOLVED, that nominations for the Board of Trustees of Blue Shield of New Jersey no longer be submitted to The Medical Society of New Jersey for its consideration and action.

Not Adopted (page Tr 132)



## #9

### "No Fault" Professional Liability Insurance

From the Union County Medical Society

(Reference Committee "C")

Whereas, the continually rising cost of professional liability insurance and the increasing incidence of malpractice are matters of great concern to all physicians; and

Whereas, the so-called "no fault" type of automobile liability insurance is proving a significant improvement over a system comparable to the present professional liability insurance system; now therefore be it

RESOLVED, that the Union County Medical

Society urges The Medical Society of New Jersey to undertake immediately a study of "no fault" accident insurance with a view to preparing plans for a "no fault" type of professional liability insurance in New Jersey.

Foregoing "resolved" amended by Reference Committee (with consent of the sponsor) to read as follows:

RESOLVED, that The Medical Society of New Jersey undertake immediately a study of "no fault" accident insurance with a view to evaluating the feasibility of plans for a "no fault" type of professional liability insurance in New Jersey.

Adopted as amended (page Tr 132)

## #10

### Continuing Medical Education as a Requirement for Retention of Membership in MSNJ

From the Board of Trustees

(Reference Committee "D")

Whereas, continuing education for physicians is being increasingly acknowledged as requisite for the maintenance of professional capability and performance in the rendition of high quality medical care; and

Whereas, the American Medical Association has referred the responsibility for accrediting continuing medical education programs within state boundaries to state medical associations; and

Whereas, continuing medical education is being mandated in various areas of the country either by legislative enactment or state medical society requirement; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey record itself as favoring the adoption as an added requirement for retention of membership; namely, that in order to continue active membership in MSNJ, members must participate in approved programs of continuing education for a total of 150 hours in a given three-year period, in accordance with AMA guidelines. (A program accredited by either the AMA Council on Medical Education or MSNJ's Committee on Medical Education is acceptable.)

Adopted (page Tr 134)

## #11

### Continuing Medical Education

From the Bergen County Medical Society

(Reference Committee "D")

RESOLVED, that The Medical Society of New Jersey again encourage its members to engage in continuing medical education as

suggested by the American Medical Association.

**Not Adopted—see notation (page Tr 134)**

## #12

### Licensure by Endorsement for Diplomates of Specialty Boards

From the Union County Medical Society

(Reference Committee "D")

Whereas, many foreign medical graduates cannot obtain licensure in New Jersey except by examination; and

situation in that jurisdiction; now therefore be it

Whereas, diplomates of specialty boards (which are AMA-approved and nationally recognized), who are also graduates of foreign medical schools labor under a similar disability, in contrast with specialty board diplomates who are graduates of United States or Canadian medical schools; and

RESOLVED, that The Medical Society of New Jersey most strongly urge the New Jersey State Board of Medical Examiners to adopt amendments to its rules, or seek remedial legislation, if necessary, to provide for the licensing, by endorsement, of specialty board diplomates without discrimination between graduates of foreign medical schools and those of United States or Canadian medical schools.

Whereas, the Commonwealth of Massachusetts in 1970 amended its medical practice act, virtually eliminating this discriminatory

**Adopted (page Tr 134)**



House of Delegates—Third Session.

## #13

### Opposition to AMA Council on Medical Education's Regulations Concerning Residency Training

Paul J. Kreutz, M.D., Delegate from Union County

(Reference Committee "D")

Whereas, the Council on Medical Education of the AMA has formulated certain recommendations, rules, and regulations with regard to residency training; and

Whereas, these rulings adversely affect most community hospitals and physicians to a major degree; and

Whereas, these rules make it almost impossible for any community hospital or association of community hospitals to comply within the criteria recommended therein; and

Whereas, the implementation of these recommendations, rules, and regulations will curtail, in the future, the education of residents in community hospitals, so that with the phasing-out of the intern program in 1975, the

residency program will be impossible to reach any fulfillment in the said hospitals; now therefore be it

RESOLVED, that The Medical Society of New Jersey express its objection to the stringent criteria set forth by the Council on Medical Education of the AMA; and be it further

RESOLVED, that MSNJ's Delegates to the AMA be instructed to express the sentiment of The Medical Society of New Jersey by resolution at the Annual Meeting of the AMA to be held on 18-22 June 1972.

*Not Adopted. The House is in accord with the need for participation of community hospitals in graduate physician education, but does not believe there should be a lowering of the criteria outlined by the AMA Council on Medical Education. (page Tr 134)*

## #14

### Accreditation of Education

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, high-quality education is essential to assure proper preparation for those engaged in health-care fields; and

Whereas, there are recognized national agencies whose duty it is to evaluate and accredit educational institutions; now therefore be it

RESOLVED, that the official position of The Medical Society of New Jersey shall be that any applicant for licensure or registration as a physician, dentist, osteopath, podiatrist,

chiropractor, or optometrist shall be a graduate of a professional institution that has been accredited by an accrediting agency recognized and approved by the National Commission of Accrediting and the Office of Education, Department of Health, Education and Welfare; and be it further

RESOLVED, that The Medical Society of New Jersey cause to be introduced and press for passage of legislation to this effect in the State of New Jersey.



**Not Adopted. Substitute Resolution for Resolutions #14 and #15 Adopted (page Tr 135)**

Whereas, bills have been introduced in many state legislatures requiring that, in the future, all U.S.-educated applicants for licensure as primary health-care providers must be graduates of educational institutions accredited by an accrediting agency recognized and approved by the National

Commission on Accrediting and the Office of Education of the Department of Health, Education, and Welfare; now therefore be it

**RESOLVED**, that The Medical Society of New Jersey cause to be introduced and press for passage at legislation to this effect in the State of New Jersey.

## #15

### Accreditation of Education

From the Essex County Medical Society

(Reference Committee "E")

Whereas, bills have been introduced in many state legislatures requiring that, in the future, all U.S.-educated applicants for licensure as primary health-care providers must be graduates of educational institutions accredited by an accrediting agency recognized and approved by the National Commission on Accrediting and the Office of Education of the Department of Health, Education, and Welfare; now therefore be it

**RESOLVED**, that such legislation be introduced in the New Jersey Legislature by The Medical Society of New Jersey; and be it further

**RESOLVED**, that nothing contained in such

legislation shall apply to any such person licensed in this State on the effective date of such legislation.

**Not Adopted. Substitute Resolution for Resolutions #14 and #15. Adopted (page Tr 135)**

Whereas, bills have been introduced in many state legislatures requiring that, in the future, all U.S.-educated applicants for licensure as primary health-care providers must be graduates of educational institutions accredited by an accrediting agency recognized and approved by the National Commission on Accrediting and the Office of Education of the Department of Health, Education, and Welfare; now therefore be it

**RESOLVED**, that The Medical Society of New Jersey cause to be introduced and press for passage of legislation to this effect in the State of New Jersey.

## #16

### Alcoholism Detection and Prevention Clinics

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, chronic alcoholism is a major medical problem in the United States; and

Whereas, it is incumbent on the medical profession to take leadership in the prevention and treatment of disease; now therefore be it

**RESOLVED**, that MSNJ's Delegates to the

AMA House of Delegates press that body to continue to work toward the greater provision of medical prevention and treatment programs and recommend that all of the medical societies in the United States establish detection and prevention clinics for chronic alcoholism.

**Adopted (page Tr 138)**

## #17

### Drug Abuse Registry

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, The Medical Society of New Jersey supported the Controlled Dangerous Substances Registry Act of 1970, now enacted into law; and

Whereas, within this Act, The Medical Society of New Jersey supported the establishment of a confidential registry of narcotic addicts and drug abusers, whose purpose is to collect, study, analyze, and evaluate statistical and epidemiological data on the extent and nature of drug abuse and addiction and on the efficacy of its treatment; and

Whereas, the purposes of the Act adequately could be served by collection of data on each drug abuser and addict *not* including his or her *full* name, address and Social Security number; and

Whereas, the requirements that physicians report to a government agency the full name, address and Social Security number of all addicted or abusing patients they treat for *any* disease inevitably will act to inhibit these patients from seeking treatment for diseases both related to and unrelated to their addic-

tion or drug abuse; and

Whereas, this requirement also will compromise the validity of the statistical and epidemiological data collected (due both to patients not seeking treatment and to physicians refusing to file a report they feel is contrary to their oath and ethics of the profession); and

Whereas, the language of the Act, in fact, states that the data collected are not truly confidential, being available to "a judge of a court of competent jurisdiction," the Attorney General, and county prosecutors (26:2G-19); now therefore be it

RESOLVED, that The Medical Society of New Jersey work with the New Jersey Department of Health to effect a change in their regulations, so that reports to the Department on drug abusers and addicts no longer must include their full names, addresses, and Social Security numbers.

Adopted (page Tr 138)



Board of Trustees—1972-1973.

## #18

# Improper Denial of Physicians' Claims Under Medicaid

From the Camden County Medical Society  
(Reference Committee "F")

Whereas, the Camden County Medical Society being ever mindful of its duties, obligations, and responsibility to protect and guard the medical interests of the general public and all physicians equally; and

Whereas, Health Services Program Staff Bulletin No. S-01.3a-Hospital Services, issued by the Department of Institutions and Agencies, Division of Medical Assistance and Health Services, states: "Whenever all or any portion of the hospital claim is denied for payment, *all physicians' claims* for services rendered during the corresponding period will also be *denied* for payment;" and

Whereas, this action abrogates the intent of Title 19, Chapter 413 of Laws of the State of New Jersey; and

Foregoing "whereas" amended by the House by rewording to read as follows:

Whereas, this action obrogates the intent of Title 19 and Chapter 413 of the Laws of New Jersey, 1968; and

Whereas, this action causes the payment of physicians' fees to be dependent on and conditioned upon relationships to which the said physicians are not parties; and

Whereas, this action is deemed to be arbitrary, capricious, and violative of this patient-physician relationship, as well as the contractual rights that exist between them; now therefore be it

RESOLVED, that The Medical Society of New Jersey formally protest the action of the Department of Institutions and Agencies in regard to this newly adopted policy; and be it further

RESOLVED, that a copy of this resolution be forwarded to the Commissioner of the Department of Institutions and Agencies with the request that immediate steps be taken to correct this intolerable situation.

Adopted as amended (page Tr 138)



Scientific Session.



## #19

### Limitation on Amphetamines and Similar Drugs

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, amphetamines and other stimulating drugs are being abused by many people; and

Whereas, a number of medical societies have recommended that their members declare a moratorium on the prescription of such drugs; and

Whereas, these drugs are of limited therapeutic value except for the treatment of narcolepsy, hyperkinetic child syndrome, certain forms of combined therapy for convulsive disorders, and possibly the first few weeks of weight-control programs; and

Whereas, injectate amphetamines have no place in weight-control programs; and

Whereas, these drugs have been re-classified

to Class II by the Bureau of Narcotics and Dangerous Drugs; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend and urge its members to limit the prescription of amphetamines and similar drugs except for the treatment of narcolepsy, hyperkinetic child syndrome, certain forms of combined therapy for convulsive disorders, and the initiation of weight-control programs.

Amended by the Reference Committee by addition of "and certain psychiatric disorders" at the end of the "resolved," to read:

RESOLVED, that The Medical Society of New Jersey recommend and urge its members to limit the prescription of amphetamines and similar drugs except for the treatment of narcolepsy, hyperkinetic child syndrome, certain forms of combined therapy for convulsive disorders, the initiation of weight-control program, and certain psychiatric disorders.

Adapted as amended (page Tr 138)

## #20

### Amendment of Medical Practice Act

From the Passaic County Medical Society

(Reference Committee "E")

Whereas, the practice of medicine in New Jersey and throughout the country has changed and continues to change rapidly in response to advancing technology and to socio-economic conditions; and

Whereas, the much-amended Medical Practice Act of New Jersey no longer relates clearly and effectively to the aforesaid changes; now therefore be it

RESOLVED, that The Medical Society of New Jersey forward recommendations to the State Legislature involving proposed changes in the State Medical Practice Act appropriate to current developments in medical and socio-economic conditions which now prevail.

Not Adapted (page Tr 136)

## #21

### Endorsement of Goals of Task Force To Conquer Uterine Cancer

Jerome A. Dolan, M.D., Delegate from Passaic County  
(Reference Committee "G")

Whereas, uterine cancer is almost 100 per cent curable when diagnosed and treated in its earliest stages; and

Whereas, an estimated 1,500 women in New Jersey will develop the disease this year and 425 will die of it; and

Whereas, most of these needless deaths could be prevented if each woman had a "Pap" test yearly; and

Whereas, an estimated 43 percent of the women in New Jersey have never had a "Pap" test; and

Whereas, the American Cancer Society, New Jersey Division, Inc., has formed a Task Force To Conquer Uterine Cancer, charged with the responsibility of an all-out effort to

reduce to the lowest possible level the number of lives lost annually to this disease in the State of New Jersey; and

Whereas, the goal of the Task Force is to accomplish its objectives by 1976, the 200th anniversary of our country; and

Whereas, the American Cancer Society, New Jersey Division, Inc., is enlisting the support of professional and lay organizations throughout the state to assist in accomplishing these goals; now therefore be it

RESOLVED, that The Medical Society of New Jersey and all its members endorse the goals of the Task Force To Conquer Uterine Cancer and pledge full cooperation in its programs.

Adopted (page Tr 140)

## #22

### Environmental Health

From the Bergen County Medical Society  
(Reference Committee "G")

Whereas, incineration which pollutes the air and diminishes natural resources is only one of the methods of disposing of an abundant product of our burgeoning population, solid waste; and

Whereas, at the present time incineration is favored as a method of disposal of solid wastes in our area; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the investigation of methods that are non-polluting and capable of recycling waste, thereby aiding in the restoration of our atmosphere, water, and terrain, as well as lessening the depletion of natural resources.

Adopted (page Tr 140)

## #23

### Fitness to Drive

From the Essex County Medical Society

(Reference Committee "G")

Whereas, there is a form sent to physicians to complete for the New Jersey Division of Motor Vehicles, which contains a question asking for an opinion as to whether or not a patient is fit to drive; and

Whereas, such a determination should be made only by the Division of Motor Vehicles; and

Whereas, in other states, such as Pennsylva-

nia, physicians are not required to make such a judgment on their patients; now therefore be it

RESOLVED, that The Medical Society of New Jersey study how this matter is being handled in contiguous states and make recommendations to the New Jersey Division of Motor Vehicles with a view to eliminating this question from their form.

Adopted (page Tr 140)

## #24

### Regulation of Hypnosis for Medical Purposes

From the Essex County Medical Society

(Reference Committee "E")

Whereas, there is presently in New Jersey no legal requirement in any way pertinent to the training or registering of hypnotherapists who use hypnosis for medical treatment; and

Whereas, local hypnotists claim to relieve or alleviate clinical patient symptoms and sometimes cure bad or unwanted habits; and

Whereas, this treatment in unqualified hands may be to the detriment of the patient; and

Whereas, past legislative attempts and corrective laws became involved with entertainment hypnosis which should not concern us; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as favoring statutory regulations which would encompass the following: hypnosis, practiced for the purpose of alleviating clinical symptoms, as in a doctor-patient relationship, should be exercised

only by a physician or dentist licensed by the New Jersey State Board of Medical Examiners or a licensed clinical psychologist; and be it further

RESOLVED, that the House of Delegates instruct MSNJ's Council on Legislation to draft, introduce, and support State legislation which will accomplish these aims.

Amended by the House by insertion of the word "licensed" before the word "physician" in line 7 of the 1st "resolved" and deletion of all language after the word "dentist" in the same line; and by deletion of "draft, introduce, and" in line 3 of the 2nd "resolved" to read:

RESOLVED, that The Medical Society of New Jersey go on record as favoring statutory regulations which would encompass the following: hypnosis, practiced for the purpose of alleviating clinical symptoms, as in a doctor-patient relationship, should be exercised only by a licensed physician or dentist; and be it further

RESOLVED, that the House of Delegates instruct MSNJ's Council on Legislation to support State legislation which will accomplish these aims.

Adopted as amended (page Tr 136)



## #25

### Practice of Medicine by Blue Shield

Arthur Bernstein, M.D., Delegate from Essex County

(Reference Committee "C")

Whereas, The Medical Society of New Jersey was instrumental in establishing the Medical-Surgical Plan of New Jersey (New Jersey Blue Shield) for the benefit of the patients; and

Whereas, the Medical-Surgical Plan has also begun to regulate the practice of medicine through administrative action; now therefore be it

RESOLVED, that The Medical Society of New Jersey remove itself from formal administrative participation in MSP as a protest against its practice of medicine by administrative fiat.

Not Adopted (page Tr 132)

Whereas, at the present time the Medical-Surgical Plan is no longer serving this function since it has more and more taken on the administrative, financial, and medical aspects of a non-profit insurance company; and

## #26

### Judicial District Hearings to Survey Opinion of Members on Various Subjects

Amended by retitling "Membership Opinion Survey on Various Subjects" (page Tr 129)

From the Union County Medical Society

(Reference Committee "A")

Whereas, the American physician is recognized world-wide for his excellent training and efficiency, and this nation has become a Mecca for medical training; and

Whereas, in the past several months, more restrictions have been placed on the private practitioner of medicine by the legislative and executive branches of both the state and national governments; and

Whereas, these physicians are under an almost constant barrage of attack and abuse from the public media and many segments of society; and

Whereas, The Medical Society of New Jersey and the AMA have shown by their response, or lack of response, an unwillingness or inability to protect their members and to effectively promote the physicians' interests; and

Whereas, the majority of this abuse is unjustified; and

Whereas, most individuals and groups—both employees and self-employed—have articulate, militant, and well-informed spokesmen to defend and protect their interests; and

Whereas, the response of the AMA has been directed towards its members rather than towards the responsible state and federal officials; and

Whereas, the AMA has adopted the ineffective policy of insisting that the only course of action is to "support candidates for Congress who believe in medicine"; and

Amended by deletion of foregoing 3 "whereas" (page Tr 129)

Whereas, it is an established fact of political life that legislators and executives of the state and federal governments can be, and are, sensitive to the pressures brought to bear by well-organized groups; now therefore be it

RESOLVED, that the House of Delegates instruct the Trustees of The Medical Society of New Jersey immediately to arrange open hearings for members of MSNJ in each of the Five (5) Districts to determine the will and opinions of members of MSNJ as to

- (1) Formation of a medical union;
- (2) Implementation of an articulate, aggressive public relations program paid for by an

assessment not to exceed \$15 per man per year;

(3) The functions of JEMPAC;

(4) Other pertinent subjects for the benefit of members of MSNJ;

And to report these findings to a special meeting of the House of Delegates in November 1972.

Amended by the Reference Committee and House as follows: Retitle resolution, "Membership Opinion Survey on Various Subjects; delete 6th, 7th, and 8th "whereas;" and reword "resolved" to read:

RESOLVED, that the House of Delegates empower the Council on Public Relations to conduct a survey, which shall include open hearings in each of the five judicial districts, to ascertain directly from the members their thinking on the subjects of (1) formation of a medical union; (2) implementation of an articulate, aggressive public relations program; (3) the function of JEMPAC; and (4) other pertinent subjects for the benefit of members of MSNJ . . . and report its findings to a special meeting of the House of Delegates in the fall of 1972.

Adapted as amended (page Tr 129)

## #27

### Blue Cross Group Enrollment

Title amended to read: Blue Cross-Blue Shield Group Enrollment (page Tr 132)

Seymour F. Kuvin, M.D., Delegate from Essex County

(Reference Committee "C")

Whereas, many members of The Medical Society of New Jersey are purchasing Blue Cross insurance through their county society group; and

Foregoing amended by inserting—"Blue Shield" after "Blue Cross"

Whereas, most of these members are currently paying rates far in excess of even persons purchasing such insurance as individuals in direct payment; and

Whereas, the respective county society groups are too small to negotiate lower rates and greater benefits for members; and

Whereas, a larger group would offer many advantages in both cost and benefits, and no disadvantages; now therefore be it

RESOLVED, that The Medical Society of New Jersey offer group enrollment in Blue Cross to all of its members, which will create a large group able to achieve the aforementioned benefits, and will eventually result in the dissolution of the ineffective smaller groups.

Amended by Reference Committee (with consent of sponsor) as follows: insert "Blue Shield" after "Blue Cross" wherever it appears (in the title, in the first "whereas," and in the "resolved"), and delete all language after the word "benefits" in the "resolved" to read:

RESOLVED, that The Medical Society of New Jersey offer group enrollment in Blue Cross-Blue Shield to all its members, which will create a large group able to achieve the aforementioned benefits.

Adopted as amended (page Tr 132)

## #28

### Compulsory Refresher Courses for Physicians

By Henry A. Brodtkin, M.D., Delegate from Essex County

(Reference Committee "D")

Whereas, the President of the College of Medicine and Dentistry of New Jersey, and the Dean of the College of Medicine and Dentistry of New Jersey—New Jersey Medical School, officially stated that they "concur with the principle of using community hospitals as a method of expanding clinical education and already have affiliations with hospitals in and around Newark giving us a total of 2200 beds for this specific purpose"; and

Whereas, many hospitals throughout the state already provide a broad spectrum of refresher courses; and

Whereas, all physicians recognize the value of

refresher courses, and the vast majority of them adopt their own method of keeping abreast of the progress of medicine; and

Whereas, any compulsory system of forcing physicians to attend refresher courses within a prescribed time would be an additional burden to family physicians and specialists; now therefore be it

RESOLVED, that The Medical Society of New Jersey looks with favor upon, and is in agreement with, the principle of voluntary systems of providing refresher courses and is opposed to any compulsory legislated method.

Not Adopted—see notation (page Tr 134)

## #29

### Sanitary Disposal of Sewage from World Trade Center Buildings in New York City

Ira S. Ross, M.D., Delegate from Essex County

(Reference Committee "G")

Whereas, the two new World Trade Center buildings in lower New York City will, when occupied, add the raw sewage of 35,000 occupants to the present discharge into the Hudson River; and

Whereas, this effluvium will present a continuous hazard of contamination to the New Jersey beach areas; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge that no certificate of occupancy be granted for these buildings until the New York Port Authority provides for sanitary disposal of sewage wastes from them.

Adopted (page Tr 140)



## #30

### Support of Senate Bill 893

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, chronic alcoholism (Jellinek's Disease) is recognized by the Bergen County Medical Society as well as by The Medical Society of New Jersey as a slow progressing and destructive pathological entity from which 45 to 50 thousand people are affected in the County of Bergen; over 300,000 in the State of New Jersey; and

Whereas, our resources in the field of early detection and prevention, rehabilitation, and treatment of chronic alcoholism are insufficient; and

Whereas, public drunkenness, an involuntary manifestation of this disease, is punishable under the existing law in the State of New Jersey, exposing its victims to jail and criminal action; and

Whereas, the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws and by it approved and recommended for enactment in all states, was approved and signed by the President of the United States; and

Whereas, under the Uniform Act alcoholics would receive necessary emergency medical

treatment and follow-up care involving medical, psychological, and social services rather than be detained on criminal charges; and

Whereas, the Honorable Jerome M. Epstein, Senator—9th District, on April 13, 1972, introduced legislation, Senate Bill 893, calling for the enactment of the New Jersey Comprehensive Intoxication and Alcoholism Control Act, which would remove public intoxication from the criminal system and would offer instead adequate programs in the field of prevention, rehabilitation, and treatment; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as favoring the enactment of such a bill, and support Senator Epstein's efforts to that end; and be it further

RESOLVED, that the Bergen County Medical Society will recommend to the House of Delegates at the Annual Meeting of The Medical Society of New Jersey (May 6-7-8-9, 1972) to approve same resolution.

Amended at the request of the sponsor by deletion of the last resolved and of the words "and be it further" in the first "resolved."

Adopted as amended (page Tr 136)



Dinner-Dance

## #31

### Disapproval of S-841

From the Hudson County Medical Society

(Reference Committee "E")

Whereas, Chapters 136 and 138, Laws of New Jersey 1971, Health Care Facilities Planning Act, allocates excessive and exclusive authority to the State Commissioner of Health; and

Whereas, arbitrary obstruction is evident by said Commissioner of Health in the case of the proposed Riverside General Hospital in the Hackensack Meadowlands Development area of Secaucus; and

Whereas, Senate No. 841 seeks to establish the financing necessary to implement Chapters 136 and 138, Laws of New Jersey 1971; and

Whereas, said bill purports to make readily available, at low interest rates, the money so desperately needed for upgrading of the health care delivery system; and

Whereas, the allotment of said financing may be as arbitrary as the handling of the above cited case; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as opposing passage of Senate No. 841.

Not Adopted—see notation (page Tr 136)

## #32

### Limitation of Right to Administer Eye Examinations for Prescription of Corrective Lenses

From Jay E. Mishler, M.D., Delegate from Atlantic County

(Reference Committee "G")

Whereas, at the 1971 Annual Meeting of the House of Delegates, it was made clear that the State Board of Medical Examiners, in the public interest, is concerned to have some means of controlling the present slack examination procedures being indulged by certain licensed physicians in the employ of commercial groups engaged in supplying corrective lenses to the public; and

Whereas, the qualified ophthalmologists practicing in this State are also concerned in the control of the present slack examination procedures being indulged by certain licensed physicians in the employ of commercial groups engaged in supplying corrective lenses

to the public; and

Whereas, the State Board of Medical Examiners is meeting in Trenton, on Wednesday, May 10, 1972, to act on this matter (N.J.A.C. 13:35-6.1, minimum examinations); now therefore be it

RESOLVED, that only physicians licensed to practice medicine and surgery and who are board-certified ophthalmologists, board eligible, or its equivalent shall be permitted to perform an eye examination for the purpose of prescribing corrective lenses.

Not Adopted—see notation (page Tr 139)





Buffet—Dance.



James W. Mackenzie, Dean, Rutgers Medical School accepting AMA-ERF check from President Davis.



President of CMDNJ, Stanley S. Bergen, Jr., accepting AMA-ERF check from President Davis.



(Left) Sherman Garrison, President of the Academy of Medicine of New Jersey, accepting check for MSNJ's annual contribution to the Academy.



---

# REFERENCE COMMITTEES

---

## Reference Committee "A"

Meyer L. Abrams, M.D., Chairman

Reference Committee "A" met on Saturday, 6 May 1972, with all members present: Doctors Dexter B. Blake, Warren E. Crane, Isaac N. Patterson, Leopold E. Thron, and the chairman. Approximately 95 delegates and members were present to discuss the various items under consideration.

### 1. President (page Tr 5)

The Committee recommends that the report be approved.

**Adopted**

### 2. Board of Trustees (page Tr 15)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee recommends approval of this portion of the report.

**Adopted**

### a. AMA Delegates (page Tr 15)

The Committee recommends that the report be approved.

**Adopted**

### b. Joint Conference of Presidents and Presidents-Elect of Component Societies (page Tr 15)

The Committee recommends that the report be approved.

**Adopted**

### 3. Secretary (page Tr 6)

The Committee recommends that the report

be approved.

**Adopted**

### 4. Judicial Council (page Tr 28)

The Committee recommends that the report be approved.

**Adopted**

### 5. Executive Director (page Tr 31)

The Committee recommends that the report be approved.

**Adopted**

### 6. Credentials (page Tr 36)

The Committee recommends that the report be approved.

**Adopted**

### 7. Resolutions:

#### a. Election of AMA Delegates—Resolution #1 (page Tr 106)

The Committee weighed the resolution and concluded that it was not in the best interest of The Medical Society of New Jersey.

The Committee recommends that the resolution be not adopted.

**Rejected**

**Resolution #1 was adopted by the House as amended by deletion of the second "Resolved"**

#### b. Liberalization of Abortion Laws—Resolution #2 (page Tr 106)

The Committee heard extensive and lengthy

arguments both in favor of and in opposition to this resolution. The deliberations of the Committee were almost equally as lengthy and culminated in a unanimous agreement to offer the following revised version as a substitute resolution for resolution #2.

*Whereas, the United States District Court has declared the law of the State of New Jersey affecting abortion to be unconstitutional, vague, and violating a woman's right to privacy; and*

*Whereas, it is a statistical fact that abortions have been, and will continue to be, performed in a clandestine manner with serious medical risks to the women involved; and*

*Whereas, the only other alternatives available to women of New Jersey are (1) to go out-of-state to unfamiliar physicians and locations to have abortions performed; (2) to have illegal abortions performed under less than optimal conditions; or (3) to bear an unwanted child; and*

*Whereas, women express the desire to have the right to determine for themselves when they shall carry through pregnancies to delivery; and*

*Whereas, there are growing societal concerns regarding overpopulation and its consequent depletion of natural resources, pollution of the natural environment and its strains on societal institutions and services; and*

*Whereas, medical knowledge and skills have reached a level where very high safety for the patient regularly exists when performed under optimal conditions in a hospital environment; and*

*Whereas, the physicians licensed in the State of New Jersey have the responsibility of providing proper medical services to their patients; and*

*Whereas, under the existing law of New Jersey, licensed physicians are exposed to*

*the possibility of prosecution for performing abortions; now therefore be it*

*RESOLVED, that The Medical Society of New Jersey strongly urge the Legislature of the State of New Jersey to draft and pass more pertinent and applicable abortion laws that include the following guidelines:*

*(a) There be no restriction upon the performance of abortion up to the end of the 16th week from commencement of pregnancy, except those of good, safe, medical practice.*

*(b) That the requirements for the performance of abortion be: (1) that the pregnant woman gives her consent; (2) that, if married, her husband either concur, or sign a release; (3) that her physician agree that her health would safely permit it, or state that her physical or mental health requires it.*

*(c) A pregnant woman, age 18 or over, should not be required to obtain parental or guardian consent for abortion.*

*(d) Pregnant girls under age 18 should have parental or guardian consent for abortion.*

*(e) Abortions should be performed only in those areas of hospitals where adequate surgical practice can be assured by competent medical personnel.*

*(f) No physician shall be required to perform an abortion, nor shall any institution be required to allow an abortion to be performed within its walls.*

*(g) No physician or medical institution can be declared liable for having performed an abortion provided that appropriate written permission was obtained and the procedure was done according to accepted standards.*

*(h) No abortion shall be permitted in New Jersey on any woman who is not a bona fide resident of the state.*

(i) *No advertising or solicitation of patients for abortions, by direct or indirect methods, in or outside the State of New Jersey, shall be permitted.*

The Committee recommends that the substitute resolution be adopted.

**Adopted (For: 147; Against: 122)**

**e. MSNJ Membership for Interns and Residents—Resolution #3 (page Tr 108)**

In the course of the protracted discussion concerning resolution #3, it was brought out that there are numerous considerations that militate against the establishment of a category of active membership in The Medical Society of New Jersey for interns and residents.

The Reference Committee recommends that resolution #3 be amended by the deletion of the 4th "Whereas", and by the deletion of the words "an active" before the term "membership category" in both the first and second "Resolveds", to read:

*RESOLVED, that this House of Delegates approve the establishment of a membership category in The Medical Society of New Jersey for interns and residents; and be it further*

*RESOLVED, that this House of Delegates instruct the Committee on Revision of Constitution and Bylaws to prepare and submit to the House of Delegates, at its next annual meeting, proposed changes in the Constitution and Bylaws of this Society which will establish a membership category for interns and residents in MSNJ and which will permit component societies to establish such a membership category if they choose to do so.*

**Adopted**

The Committee further recommends that the resolution be adopted as amended.

**Adopted**

**d. Nominating Procedure—Resolution #4 (page Tr 109)**

The Reference Committee found merit in the intent of this resolution, but it feels that in its present form the resolution should not be adopted.

The Committee recommends that resolution #4 be not adopted, but that it be referred to the Board of Trustees with the request that the Board establish an ad hoc committee to investigate the entire matter and report back to the House of Delegates at the 207th Annual Meeting.

**Adopted**

**e. Prompt Transmittal of Information to Component Societies—Resolution #5 (page Tr 110)**

The Committee agrees with the basic intent of this resolution, but also feels that this resolution is redundant in that its declared intent is being and has been fully implemented by The Medical Society of New Jersey.

The Committee recommends that the resolution be not adopted.

**Adopted**

**f. Survey of Methods to Increase AMA Membership—Resolution #6 (page Tr 110)**

The Committee recommends that the resolution be adopted.

**Adopted**

**g. Judicial District Hearings to Survey Opinion of Members on Various Subjects—Resolution #26 (page Tr 121)**

The Committee agrees with the general intent and purpose of this resolution, and recommends that the resolution be amended as follows: that it be re-titled "*Membership Opinion Survey on Various Subjects*"; that the 6th, 7th, and 8th "Whereas" be deleted; and that the "Resolved" be revised to read:



*RESOLVED, that the House of Delegates empower the Council on Public Relations to conduct a survey to ascertain directly from the members their thinking on the subjects of*

*(1) Formation of a medical union;*

*(2) Implementation of an articulate, aggressive public relations program;*

*(3) The function of JEMPAC;*

*(4) Other pertinent subjects for the benefit of members of MSNJ . . .*

*and report its findings to the House of Delegates at the 207th Annual Meeting.*

The Committee recommends that the resolution be adopted as amended.

Foregoing RESOLVED amended by the House as follows:

Following the word "survey" insert "which shall include open hearings in each of the five Judicial Districts"; and following "and report its findings to" insert "a special meeting of the House of Delegates in the fall of 1972." The amended RESOLVED reads:

Resolved, that the House of Delegates empower the Council on Public Relations to conduct a survey which shall include open hearings in each of the five Judicial Districts to ascertain directly from the members their thinking on the subjects of

(1) formation of a medical union;

(2) implementation of an articulate, aggressive public relations program

(3) the function of JEMPAC;

(4) other pertinent subjects for the benefit of members of MSNJ . . .

and report its findings to a special meeting of the House of Delegates in the fall of 1972.

Adopted as amended by the House

## Reference Committee "B"

Irving P. Borsher, M.D., Chairman

Reference Committee "B" met on Saturday, 6 May 1972, with the following members present: Doctors Daniel J. O'Regan, Francis A. Pflum, Elbert H. Pogue, and the chairman. Doctor Blackwell Sawyer was unable to attend. Approximately 20 delegates and members were present to discuss the various items under consideration.

### 1. Board of Trustees—Items

#### a. Expansion of Headquarters' Facilities (page Tr 16)

The Committee recommends that the report be approved.

Adopted

#### b. Statewide Automated Bookkeeping, Accounting, and Billing System (page Tr 17)

The Committee recommends that the report be approved.

Adopted

### 2. Treasurer (page Tr 8)

The Committee recommends that the report be approved, with special commendation to the Treasurer for the excellence of his efforts.

Adopted

### 3. Finance and Budget (page Tr 37)

The Committee recommends that the report be approved, and further recommends—with respect to the allocation of funds to the Academy of Medicine—that The Medical Society of New Jersey re-evaluate its relationship to the Academy of Medicine relative to the contribution of further funds for 1973-1974 and thereafter.

Adopted

### 4. Medical Student Loan Fund (page Tr 48)

The Committee recommends that the report be approved.

Adopted

**5. Physicians' Relief Fund (page Tr 86)**

The Committee recommends that the report be approved.

**Adopted**

**6. Publication (page Tr 51)**

The Committee recommends that the report

be approved.

**Adopted**

**7. Project Hope/Vietnam (page Tr 86)**

The Committee recommends that the report be approved.

**Adopted**

## Reference Committee "C"

Sherman Garrison, M.D., Chairman

Reference Committee "C" met on Sunday, 7 May 1972, with all members present: Doctors Donald P. Burt, Karl T. Franzoni, Carl A. Restivo, Edward A. Schauer, and the chairman. Approximately 65 delegates and members were present to discuss the various items under consideration, most of whom stayed through a lively discussion.

**1. Board of Trustees—Items**

**a. Adoption of AMA System of Coding and Nomenclature (page Tr 17)**

The Committee recommends that the report be approved.

**Adopted**

**b. Continuance of MSP-HSP Coverage for Children of Subscriber Physician (page Tr 18)**

The Committee recommends that the report be approved.

**Adopted**

**c. MSP Board of Trustees—Nominations (page Tr 19)**

The Committee recommends that the report be approved.

**Adopted**

**2. Medical-Surgical Plan of New Jersey (page Tr 89)**

A lengthy discussion developed regarding the Medical-Surgical Plan. The Committee recommended, and representatives of the Plan agreed to, the following proposals:

a. The Plan's statement regarding maximum benefits and participating physicians will be reworded.

b. Physicians will be notified of the rejection of in-patient claims prior to the notification of the patient.

c. The necessity for clarifying terms of the contract to the patient, particularly in regard to exclusions, was reaffirmed.

The Committee and those present felt that this discussion provided an excellent forum for dealing with our mutual problems and the Committee was impressed by the receptiveness of the representatives of Blue Cross-Blue Shield to the proposals.

The Committee recommends that the report be approved.

**Adopted**

3. Medical Defense and Insurance (page Tr 40)

The Committee commends the excellent and detailed report of this Committee.

The Committee recommends that the report be approved.

**Adopted**

4. Retirement Plan for Physicians (page Tr 87)

The Committee commends the efficient and effective work of this Committee.

The Committee recommends that the report be approved.

**Adopted**

5. Resolutions:

a. Avoidance of Conflicts of Interest—Resolution #7 (page Tr 111)

The Committee agrees with the obvious purpose of this resolution. It is of the opinion, however, that the resolution offers no safeguard or assurance that the personal integrity of physicians does not itself afford.

The Committee recommends that the resolution be not adopted.

**Adopted**

b. Discontinuance of Practice of Clearing Nominations for MSP Board Through MSNJ—Resolution #8 (page Tr 111)

c. Practice of Medicine by Blue Shield—Resolution #25 (page Tr 121)

The Committee considered resolutions #8 and #25 together. The Committee reaffirms the importance of a continuing relationship between the Medical Society of New Jersey and Blue Cross-Blue Shield of New Jersey.

The Committee recommends that these resolutions be not adopted.

**Adopted**

d. "No Fault" Professional Liability Insurance—Resolution #9 (page Tr 112)

The Committee considered resolution #9 at length and, with the consent of the sponsor, reworded it as follows:

*RESOLVED, that The Medical Society of New Jersey undertake immediately a study of "no fault" accident insurance with a view to evaluating the feasibility of plans for a "no fault" type of professional liability insurance in New Jersey.*

The Committee recommends that the resolution be adopted as reworded.

**Adopted**

e. Blue Cross Group Enrollment—Resolution #27 (page Tr 122)

This resolution was discussed at length, and, with the permission of the sponsor, it was amended in the following manner:

1. By insertion of the name "Blue Shield" after "Blue Cross" wherever it appears; and

2. By deleting all language in the "Resolved" following the words "the aforementioned benefits," to read:

*RESOLVED, that The Medical Society of New Jersey offer group enrollment in Blue Cross-Blue Shield to all of its members, which will create a large group able to achieve the aforementioned benefits.*

The Committee recommends that the resolution be adopted as amended.

**Adopted**



# Reference Committee "D"

Robert H. Areson, M.D., Chairman

Reference Committee "D" met on Saturday, 6 May 1972, with all members present: Doctors William A. Dwyer, Jr., Robert S. Gamon, Jr., Peter H. Marvel, Raymond A. McCormack, Jr., and the chairman. Approximately 60 delegates and members were present to discuss the various items under consideration.

## 1. Board of Trustees—Items

### a. Problems Affecting Internships and Residencies in New Jersey Hospitals (page Tr 19)

The Committee recommends that the report be approved.

**Adopted**

### b. SAMA's MECO Project (page Tr 20)

The Committee recommends that the report be approved.

**Adopted**

## 2. Medical Education (page Tr 45 and Supplemental (page Tr 46)

The Committee considered the report of the Committee on Medical Education and was pleased to note that there will be about two hundred first-year medical students in the two schools of the College of Medicine and Dentistry of New Jersey by the fall of this year. We are assured that these schools are placing an emphasis on family practice.

Included in both the initial and supplemental reports of the Committee on Medical Education were several items of vital importance to members of The Medical Society of New Jersey. These include the "Accreditation of Programs of Continuing Physician Education in New Jersey" and the question of "Physician Participation in Continuing Medical Education."

The Reference Committee supports these proposals offered by the Committee on Medical Education but recommends that because of

the increased work load and responsibilities created by them, the membership of the Committee on Medical Education be expanded to include representatives from the various areas of medical practice.

**Adopted**

The Committee recommends that the report and supplemental report be approved.

**Adopted**

## 3. Emergency Medical Care (page Tr 83)

The Committee considered the report of the Committee on Emergency Medical Care. Your Reference Committee offers the following amendment to the last paragraph on page Tr 84 dealing with Emergency Medical Identification. The 10th line from the bottom would be amended by inserting the word "help" before the word "ensure." The sentence would then read: *This would help ensure his obtaining proper medical aid when needed.*

The Committee would also like to offer an amendment to the final paragraph on page Tr 85 of this same report dealing with a "Training Program for Medical Technicians—Emergency Department (Hospital)." We recommend that the next to last sentence, "This program would be a boon for those unemployed medical corpsmen of the armed forces and for others seeking their niche in society," be deleted.

**Adopted**

Your Reference Committee also feels that in view of certain serious and far-reaching implications present in this proposal. The Medical Society of New Jersey should not formally proceed until the several details and problems mentioned in the last sentence of this same paragraph have been resolved.

The Committee recommends that the report be approved as amended.

The House subsequently voted to postpone indefinitely consideration of the last paragraph in its entirety.

Adopted with the exclusion of the final paragraph of the report of the Committee on Emergency Medical Care

#### 4. Medicine and Religion (page Tr 85)

The Committee recommends that the report be approved.

Adopted

#### 5. Resolutions:

##### a. Continuing Medical Education as a Requirement for Retention of Membership in MSNJ—Resolution #10 (page Tr 112)

This resolution is in conformity with the supplemental report of the Committee on Medical Education.

The Committee recommends that the Resolution #10 be adopted.

Adopted

##### b. Continuing Medical Education—Resolution #11 (page Tr 113)

The subject matter has been covered in Resolution #10 which seems appropriately far more positive and whose adoption has already been recommended.

The Committee therefore recommends that Resolution #11 be not adopted.

Adopted

##### c. Licensure by Endorsement for Diplomates of Specialty Boards—Resolution #12 (page Tr 113)

The Committee recommends that Resolution #12 be adopted.

Adopted

##### d. Opposition to AMA Council on Medical Education's Regulations Concerning Residency Training—Resolution #13 (page Tr 114)

The Committee is in accord with that portion of the resolution citing the need for the participation of community hospitals in recognized programs of graduate physician education but does not believe there should be a lowering of the criteria presently outlined by the AMA Council on Medical Education.

The Committee therefore recommends that Resolution #13 be not adopted.

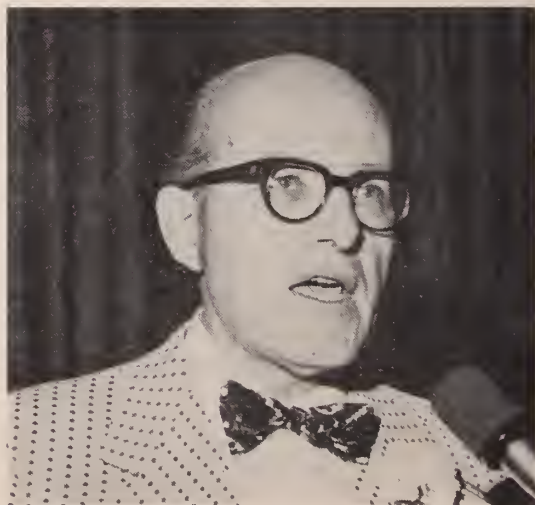
Adopted

##### c. Compulsory Refresher Courses for Physicians—Resolutions #28 (page Tr 123)

The intent of this resolution is to avoid "compulsory legislated" accreditation. The Reference Committee felt that adoption of the supplemental report of the Committee on Medical Education and Resolution #10 affords the best insurance against this possibility at this time.

The Committee therefore recommends that Resolution #28 be not adopted.

Adopted



Speaker of the House, Henry J. Mincut.

# Reference Committee "E"

Paul J. Kreutz, M.D., Chairman

Reference Committee "E" met on Sunday, 7 May 1972 with all members present: Doctors Anthony P. DeSpirito, Vincent H. Gillson, Edward A. Jasionowski, Charles O. Tyler, and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration.

## 1. Board of Trustees—Items

### a. Committee on Extension to Interns and Residents of Power to Sign Certain Legal Documents (page Tr 18)

The Committee recommends that the report be approved.

**Adopted**

### b. Crash Program on Blood Procurement (page Tr 18)

The Committee recommends that the report be approved.

**Adopted**

### c. Legislation to Provide that Blood Transfusing is a Service Not a Sale (page Tr 20)

The Committee recommends that the report be approved.

**Adopted**

### d. Legislative Approach to Professional Liability (page Tr 21)

The Committee recommends that the report be approved.

**Adopted**

### e. Rescinding of Eye Medication Ruling (page Tr 21)

The Committee recommends that the report

be approved.

**Adopted**

### f. Use of Physical Therapy Modalities by Chiropractors (page Tr 21)

The Committee recommends that the report be approved.

**Adopted**

## 2. Legislation (page Tr 55) and Supplemental (page Tr 63)

The Committee recommends the approval of the entire report of the Council on Legislation and commends the Council on Legislation and the staff for its excellent job.

**Adopted**

It was brought to the attention of this Committee that a bus safety bill, Assembly 836, had not been considered by the Council on Legislation. We urge the Council on Legislation to consider this legislation at its earliest opportunity. This bill is a companion measure to Assembly 837 and Assembly 838 all relating to school bus safety. We encourage members of The Medical Society of New Jersey to express their interest in and approval of legislation related to school bus safety.

## 3. Public Relations (page Tr 81)

The Committee recommends that the report be approved and commends the Council on Public Relations for a job well done.

**Adopted**

## 4. Resolutions:

### a. Accreditation of Education—Resolution #14 (page Tr 114)

### b. Accreditation of Education—Resolution #15 (page Tr 115)



Resolutions #14 and #15 were considered jointly since they both were concerned with the same subject. The Committee decided to merge the better features of both resolutions into a substitute resolution to read as follows:

*Whereas, bills have been introduced in many state legislatures requiring that, in the future, all U.S.-educated applicants for licensure as primary health-care providers must be graduates of educational institutions accredited by an accrediting agency recognized and approved by the National Commission on Accrediting and the Office of Education of the Department of Health, Education, and Welfare; now therefore be it*

*RESOLVED, that The Medical Society of New Jersey cause to be introduced and press for passage of legislation to this effect in the State of New Jersey.*

The sponsors of both resolutions have approved this substitute resolution.

The Committee recommends that this substitute resolution be adopted.

**Adopted**

c. Amendment of Medical Practice Act—Resolution #20 (page Tr 118)

The Committee recommends that this resolution be not adopted for the reason that it lacks specificity.

**Adopted**

d. Regulation of Hypnosis for Medical Purposes—Resolution #24 (page Tr 120)

The Committee recommends that this resolution be not adopted for the reason that legislation to effect the goals of this resolution has already been introduced, this year, into the legislature (S-965 and A-1121).

**Not Adopted**

Resolution #24 was adopted by the House with the **RESOLVEDS** amended to read:

**RESOLVED**, that The Medical Society of New Jersey go on record as favoring statutory regulations which would encompass the following: hypnosis, practiced for the purpose of alleviating clinical symptoms, as in a doctor-patient relationship, should be exercised only by a licensed physician or dentist; and be it further

**RESOLVED**, that the House of Delegates instruct MSNJ's Council on Legislation to support state legislation which will accomplish these aims.

e. Support of Senate Bill 893—Resolution #30 (page Tr 124)

The Committee recommends that this resolution be adopted with the last "Resolved" deleted at the request of its sponsor.

The Committee recommends that this resolution be adopted as amended.

**Adopted**

f. Disapproval of S-841—Resolution #31 (page Tr 125)

The Committee recommends that this resolution be not adopted for the reason that the funding of health-care facilities advocated by Senate Bill 841 is desirable.

**Adopted**

## PATRONIZE OUR ADVERTISERS

They Merit Your Support

# Reference Committee "F"

Frank R. Begen, M.D., Chairman

Reference Committee "F" met on Sunday, 7 May 1972, with all members present: Doctors Hillel M. Ben-Asher, Charles H. Calvin, Josiah C. McCracken, Jr., William R. Muir, and the chairman. Approximately 32 delegates and members were present to discuss the various items under consideration.

## 1. Board of Trustees—Items

### a. Ad Hoc Committee to Study and Make Recommendations Concerning the Foundation Approach to Medical Care (page Tr 22)

The Committee recommends that the House of Delegates support the recommendation of the Ad Hoc Committee that the Board of Trustees appoint a steering committee to formulate a specific foundation plan for the State Society.

Adopted

### b. Approval Criteria of Joint Commission on Accreditation of Hospitals (page Tr 23)

The Committee recommends that the report be approved.

Adopted

### c. Baccalaureate Program for Physicians' Associates (page Tr 23)

The Committee recommends that the report be approved.

Adopted

### d. Criteria Used by Fiscal Intermediaries in Reviewing Physicians' Services (page Tr 23)

The Committee recommends that the report be approved.

Adopted

### e. Liaison Committee with Fiscal Intermediaries (page Tr 23)

The Committee recommends that the report be approved.

Adopted

### f. Special Committee to Assist Existing Governmental Health Planning Agencies (page Tr 23)

The Committee recommends that the report be approved.

Adopted

### g. State Peer Review Committee (page Tr 24)

The Committee recommends that the report be approved.

Adopted

### h. Support of HMO Concept (page Tr 25)

The Committee recommends that the report be approved.

Adopted

## 2. Medical Services (page Tr 68)

The Committee recommends that the report be approved.

Adapted (For: 131; Against: 122)

Subsequent decision to reconsider three items in the report of Council on Medical Services—Position Statement on Physicians' Assistants, Resolution #9 (1971), and Resolution #18 (1971)—resulted, after lengthy parliamentary procedures, in approval of each by separate vote. The effect was to confirm the original vote to approve the Council's report.

## 3. Occupational Health, Workmen's Compensation, and Rehabilitation (page Tr 70)

The Committee recommends that the report be approved.

Adopted

#### 4. Mental Health (page Tr 71)

The Committee **recommends** that the report be approved.

##### **Adopted**

#### 5. Alcoholism (page Tr 72)

The Committee **recommends** that the report be approved.

##### **Adopted**

#### 6. Drug Abuse (page Tr 73)

The Committee **recommends** that the report be approved.

##### **Adopted**

#### 7. Emotional Disorders of Childhood and Adolescence (page Tr 74)

The Committee **recommends** that the report be approved.

##### **Adopted**

#### 8. Mental Retardation (page Tr 74)

The Committee **recommends** that the report be approved.

##### **Adopted**

#### 9. Neurological and Related Disorders (page Tr 75)

The Committee **recommends** that the report be approved.

##### **Adopted**

#### 10. Resolutions:

##### a. Alcoholism Detection and Prevention Clinics—Resolution #16 (page Tr 115)

The Committee agrees with the intent of this resolution, but **recommends** that it be not adopted because of its ambiguity, and further **recommends** that it be referred to the Com-

mittee on Alcoholism of the Council on Mental Health.

##### **Not Adopted**

**Resolution #16 was adopted upon motion by the House.**

##### b. Drug Abuse Registry—Resolution #17 (page Tr 116)

The Committee recommends that Resolution #17 be adopted.

##### **Adopted**

##### c. Improper Denial of Physicians' Claims Under Medicaid—Resolution #18 (page Tr 117)

The third "whereas" is changed by inserting "1968" after "New Jersey," to read:

*"Whereas, this action abrogates the intent of Title 19 and Chapter 413 of the Laws of New Jersey, 1968; and"*

The Committee agrees with the intent of the resolution and recognizes the complexity of the problem suggested by this resolution. However, the Committee feels that this problem can best be handled by referral to the Medicaid Negotiating Committee of MSNJ; therefore, the Committee **recommends** that Resolution #18 be not adopted.

##### **Not Adopted**

**Resolution #18 adopted upon motion by the House (Reference Committee suggested amendment—rewording of the third "whereas"—is contained in adopted resolution)**

##### d. Limitation on Amphetamines and Similar Drugs—Resolution #19 (page Tr 118)

The Committee **recommends** that Resolution #19 be adopted; however, it further **recommends** the following revision to the "Resolved" portion of the resolution:

*"RESOLVED, that The Medical Society of New Jersey recommend and urge its members to limit the prescription of amphetamines and similar drugs, except for the treatment of narcolepsy, hyper-kinetic child syndrome, certain forms of combined ther-*



apy for convulsive disorders, the initiation of weight-control programs, and certain psychiatric disorders."

Adopted as amended by the Reference Committee (Motion from floor of House to amend Reference Committee's revised RESOLVED by deleting "and certain psychiatric disorders" was defeated.)

## Reference Committee "C"

Arthur C. Dietrick, M.D., Chairman

Reference Committee "C" met on Saturday, 6 May 1972, with all members present: Doctors Harry W. Fullerton, Jr., Jesse T. Glazier, Roy A. Morrow, Frederick L. Perl, and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

### 1. Board of Trustees—Items

#### a. FDA Policy on Fixed Combination Drugs (page Tr 25)

The Committee recommends that the report be approved.

Adopted

#### b. Minimum Eye Examination (page Tr 26)

The Committee recommends that the report be approved.

Adopted

#### Limitation of Right to Administer Eye Examinations for Prescription of Corrective Lenses—Resolution # 32 (page Tr 125)

Basically, the members of the Committee found themselves fundamentally in disagreement with the action taken by the Board of Trustees as reported in that section of the Board report dealing with minimum eye examinations. In connection with this matter of minimum eye examinations, the members of your reference committee felt that the Board's action taken on April 16, approving the State

Board's proposed new regulations governing eye examinations for refractions was less than satisfactory.

Accordingly, the Committee recommends that Resolution #32 be adopted, with the "Resolved" amended to read:

*RESOLVED, that only licensed physicians who are qualified ophthalmologists, or their equivalent, shall be permitted to perform an eye examination for the purpose of prescribing corrective lenses.*

Rejected

The House voted not to adopt Resolution #32

#### c. Smallpox Vaccination (page Tr 26)

The Committee recommends that the report be approved.

Adopted

#### d. Transfusion-Associated Hepatitis (page Tr 27)

The Committee recommends that the report be approved.

Adopted

#### e. Uniformity of Blood Banking Procedures in New Jersey (page Tr 27)

The Committee recommends that the report be approved.

Adopted

## 2. Public Health (page Tr 76)

The Committee recommends that the report be approved.

**Adopted**

## 3. Cancer Control (page Tr 77)

The Committee recommends that the report be approved.

**Adopted**

## 4. Child Health (page Tr 78)

The Committee recommends that the report be approved.

**Adopted**

## 5. Conservation of Vision, Hearing, and Speech (page Tr 79)

The Committee recommends that the report be approved.

**Adopted**

## 6. Environmental Health (page Tr 79)

The Committee recommends that the report be approved.

**Adopted**

## 7. Maternal and Infant Welfare (page Tr 80)

With the permission of the Chairman of the Special Committee on Maternal and Infant Welfare, the Reference Committee suggests that the report be revised as follows:

### RH AND BLOOD TYPING

The Council on Public Health referred to this Committee the question of whether or not RH factor and blood typing should be performed routinely on all pregnant females at State expense. The Committee feels this is especially desirable in view of the increasing utilization of RHOgam. We have therefore requested that the Board of Trustees inform the

Department of Health that routine determinations of RH factor and blood type should be performed on all pregnant females upon the order of their treating physician, and at State expense *when necessary*.

(The words in italics are to be added to the report.)

The Committee recommends that the report be approved.

**Adopted**

## 8. Resolutions:

### a. Endorsement of Goals of Task Force to Conquer Uterine Cancer—Resolution #21 (page Tr 119)

The Committee recommends that Resolution #21 be adopted.

**Adopted**

### b. Environmental Health—Resolution #22 (page Tr 119)

The Committee recommends that Resolution #22 be adopted.

**Adopted**

### c. Fitness to Drive—Resolution #23 (page Tr 120)

The Committee recommends that Resolution #23 be adopted.

**Adopted**

### d. Sanitary Disposal of Sewage from World Trade Center Buildings in New York City—Resolution #29 (page Tr 123)

The Committee recommends that Resolution #29 be adopted.

**Adopted**

I thank members of the Committee and the delegates attending for their time and interest.

# Reference Committee "H"

Robert A. Weinstein, M.D., Chairman

Reference Committee "H" met on Sunday, 7 May 1972, with all members present: Doctors James E. Brennan, Robert E. Fullilove, Jr., Samuel B. Pole, III, Sidney Woltz, and the chairman. Approximately 12 delegates and members were present to discuss the various items under consideration.

## 1. Board of Trustees—Item

### Committee on Resolutions (page Tr 27)

Regarding the membership of the Committee on Resolutions, the Reference Committee suggests that the same procedure be followed in appointing the members of the Committee; that is, that the three most recent past presidents of the Society be appointed.

The Committee recommends that the report be approved.

**Adopted**

## 2. Annual Meeting (page Tr 32)

The Reference Committee commends the work of the Committee on Annual Meeting.

The Reference Committee recommends that the format used this year for the meetings of the reference committees be followed again next year to allow a fair basis of comparison to be established.

**Adopted**

The Committee recommends that the report be approved.

**Adopted**

## 3. Scientific Exhibits (page Tr 34)

The Reference Committee commends the chairman for his excellent report. The Committee suggests that in order to stimulate the presentation of more scientific exhibits

by students in New Jersey's medical schools, the Society award cash prizes for the two most outstanding scientific exhibits by medical students, and that the Committee on Scientific Exhibits be responsible for choosing the winning exhibits.

The Committee recommends that the report be approved.

**Adopted**

## 4. Scientific Program (page Tr 35)

The Reference Committee applauds the work of the Committee on Scientific Program and its chairman, and endorses the work that the Committee has done in its efforts to increase attendance at the annual meeting. The Reference Committee noted that the Committee on Scientific Program has once again succeeded in having eminent guest speakers participate in the scientific program.

The Committee recommends that the report be approved.

**Adopted**

## 5. Honorary Membership (page Tr 36)

The Committee recommends that the report be approved.

**Adopted**

## 6. Woman's Auxiliary Advisory (page Tr 54)

The Reference Committee commends the Woman's Auxiliary for their excellent work in trying to reach their goal of \$10,000 for the AMA-ERF Student Loan Fund commitment.

The Committee recommends that the report be approved.

**Adopted**



## 7. Nominations for Emeritus Membership and Supplemental (page Tr 102, Tr 103)

The Committee recommends that the report be approved.

**Adopted**

# Reference Committee on Constitution and Bylaws

Thomas C. DeCccio, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Saturday, 6 May 1972, with all members present: Doctors Herbert D. Axilrod, Merton L. Griswold, E. Spencer Paisley, Howard D. Slobodien, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

## 1. Board of Trustees—Item

**Affiliate or Adjunct Membership in MSNJ**  
(page Tr 28)

The Committee recommends that the report be approved.

**Adopted**

## 2. Revision of Constitution and Bylaws (page Tr 52)

### a. Proposed Amendment to the Constitution—Appointment of Vice-Speaker (page Tr 52)

Attention is called to the proposed amendment appearing on page Tr 53 of the annual report of the Committee on Revision of Constitution and Bylaws, and it is noted that said amendment was read at the 1971 House of Delegates, and a second reading took place at the first session of the 1972 House of Delegates.

The Committee recommends that the proposed Constitutional amendment be approved. (In accordance with Article XII—Amendments to the Constitution—under the heading of Procedure for Second Year, favorable action

on this Constitutional amendment by the House of Delegates requires “adoption by a two-thirds ( $\frac{2}{3}$ ) vote of the members of the House of Delegates present and voting at the final session”).

**Adopted**

### b. Proposed Amendment to the Constitution—Affiliate Membership (page Tr 53)

After a considerable discussion referable to the intent of the amendment, the Committee recommends, for the purposes of clarity and without changing the intent of the amendment, that the words “or reside” after the word practice be deleted, that after the word directed, there be introduced the phrase “through the component medical society”, and that after the words Medical Defense and Insurance the words “of The Medical Society of New Jersey” be inserted so that the amendment will read:

#### *Article IV—Organization of the Society Section 1—Composition*

*Affiliate Membership may be granted but recipients may neither vote nor hold office.*

#### *Section 8—Affiliate Members*

*Affiliate Members shall be physicians who have been active members for at least five consecutive years but who no longer practice (or reside) in New Jersey. Applications for Affiliate Membership shall be directed, through the component medical society, to*

*the Standing Committee on Medical Defense and Insurance of The Medical Society of New Jersey for consideration and action. Affiliate Members shall be eligible to continue all insurance coverages offered by the Society except those relating to professional liability. The dues for Affiliate Members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.*

(Bracketed words indicate the recommended deletion by the Reference Committee. Bold-face portion indicates the recommended addition by the Reference Committee.)

(In accordance with Article XII—Amend-

ments to the Constitution—under the heading of the Procedure for First Year, favorable action on this constitutional amendment by the House of Delegates requires “adoption of the report of the Reference Committee by a majority vote of the members of the House of Delegates present and voting at the final session.”)

**Adopted as amended**

The Reference Committee wishes to express its gratitude to all those who attended, and particularly to Mr. Vincent A. Maressa who contributed to the discussion in answering many of the questions that were posed by those present.



Buffet—Dance.

# Report of Nominating Committee and Election – May 7, 1972

Emanuel M. Satulsky, M.D., Chairman

OFFICE	TERM	NOMINEE AND COUNTY
President-Elect	1 year	Matthew E. Boylan, M.D., Hudson
1st Vice-President	1 year	James A. Rogers, M.D., Passaic
2nd Vice-President	1 year	John J. McGuire, M.D., Essex
Secretary	1 year	Louis F. Albright, M.D., Monmouth
Treasurer	1 year	Samuel J. Lloyd, M.D., Mercer
Trustees:		
1st District	3 years	Robert C. Anderson, M.D., Essex
1st District	3 years	Edward G. Bourns, M.D., Union
2nd District	3 years	Charles L. Cunniff, M.D., Hudson
2nd District	3 years	Richard E. Lang, M.D., Passaic
3rd District	3 years	Howard D. Slobodien, M.D., Middlesex
3rd District	3 years	David Eckstein, M.D., Mercer
4th District	3 years	L. Edward Orna, M.D., Camden
Judicial Councilors:		
1st District	3 years	Thomas S. P. Fitch, M.D., Union
4th District	3 years	Frederick W. Durham, M.D., Camden
AMA Delegates:		
	2 years	Luke A. Mulligan, M.D., Bergen
	2 years	Emanuel M. Satulsky, M.D., Union
	2 years	Frank J. Hughes, M.D., Camden
	2 years	John F. Kustrup, M.D., Mercer
AMA Alternate Delegates:		
	1 year	George L. Benz, M.D., Essex*
	2 years	Louis F. Albright, M.D., Monmouth
	2 years	John J. Bedrick, M.D., Hudson
	2 years	Nicholas A. Bertha, M.D., Morris
Delegates and Alternate Delegates to Other States:		
New York		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	Josiah C. McCracken, Jr., M.D., Atlantic
Connecticut		
Delegate	1 year	Warren H. Knauer, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation		
5th District	3 years	John S. Madara, M.D., Salem
6th Member	3 years	Winton H. Johnson, M.D., Bergen
Medical Services		
5th District	3 years	David R. Brewer, Jr., M.D., Gloucester
6th Member	3 years	David Flinker, M.D., Burlington
Mental Health		
3rd District	3 years	Robert S. Garber, M.D., Somerset
6th Member	3 years	Evelyn P. Ivey, M.D., Monmouth
Public Health		
5th District	3 years	Robert G. Salasin, M.D., Cape May
6th Member	3 years	Francis E. Rieman, M.D., Hudson
Public Relations		
2nd District	3 years	Frank R. Begen, M.D., Bergen
5th District	3 years	Gastone A. Milano, M.D., Atlantic
Standing Committees:		
Annual Meeting	3 years	Robert E. Verdon, M.D., Bergen
Finance and Budget	3 years	Louis G. McAfoos, Jr., M.D., Camden
Medical Defense and Insurance	1 year	Anthony P. DeSpirito, M.D., Monmouth
	3 years	Paul J. Kreutz, M.D., Union
Medical Education	1 year	Frank C. Snopce, M.D., Hunterdon
	3 years	Edward H. Weiser, M.D., Sussex
Publication	3 years	John F. Marshall, M.D., Mercer
Woman's Auxiliary Advisory	3 years	William J. Roe, M.D., Bergen

\* Nominated and elected by the House to fill unexpired term of Emanuel M. Satulsky, M.D., who resigned after being elected AMA Delegate.



*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Would it be useful  
in clinical practice to have  
government predetermine  
drugs of choice?**

# Opinion

**Results of a survey of physicians:**

**13.3%**

**Yes, it would be useful.**

**86.7%**

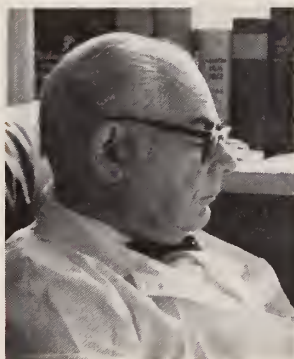
**No, it would not be useful.**

# Dialogue

## Would it be useful in clinical practice to have government predetermine drugs of choice?

### Doctor of Medicine

Walter Modell, M.D.,  
Professor of Pharmacology,  
Cornell University  
Medical College,  
Editor,  
Clinical Pharmacology  
& Therapeutics,  
Drugs of Choice,  
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial dif-

ferences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain

segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy

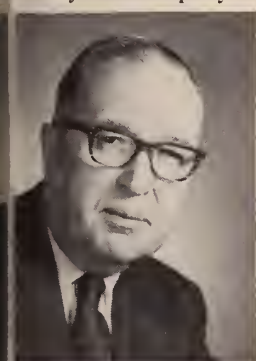
in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. As I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the "drug of choice" in these areas of medical practice.

# Maker of Medicine

neth G. Kohlstaedt, M.D.,  
Vice President,  
Medical Research,  
Eli Lilly and Company



In my opinion, it is not the function of any government or private regulatory agency to designate a "drug of choice." This determination should be made by the physician after he has received full information on the properties of a drug, and then it will be based on experience with this drug and his knowledge of the individual patient who is seeking treatment. An evaluation of comparative efficacy were to be made, particularly by government, at the time a new drug is being approved for marketing, it would be a great disservice to medicine and thus to the patient and consumer. For example, when a new therapeutic agent is introduced, on the basis of limited knowledge, it may be considered to be more potent, more effective, or safer than products already on the market. Conceivably, at the time the new drug is labeled "the drug of choice." But as additional clinical experience is accumulated, new evidence may become available. Then, it may be apparent

that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B<sub>12</sub> as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. How-

ever, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "drugs of choice" is to be avoided.

## Opinion & Dialogue

What is your opinion, doctor?

Send us your comments on the above issue.



The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005





**Ampicillin, Carbenicillin, Oxacillin...**

# IMAGINE YOUR PRACTICE WITHOUT THEM

In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

Need we say more?

Prescribe the discoverer's brands:

**Totacillin<sup>®</sup>** (ampicillin trihydrate)

**Pyopen<sup>®</sup>** (disodium carbenicillin)

**Bactocill<sup>®</sup>** (sodium oxacillin)

and more to come

**Beecham-Massengill  
Pharmaceuticals **BMP****

Div. of Beecham Inc. Bristol, Tennessee 37620

- ☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.
- ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
- ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

Announcing—  
a new commitment to health care

# Roche Clinical Laboratories

Professional  
Consultation

An Advanced  
Diagnostic Center for  
Standard, Endocrine  
and Special Laboratory  
Tests

Computerized  
Quality Control  
to prevent error

Automated Diagnostic Analysis  
for most tests

A Unique Professional  
Staff of Research  
Scientists and Practicing  
Clinicians

Personal Service through Roche Professional Representatives.

The Roche Professional Representative welcomes the opportunity to introduce our laboratory service to you.  
Please fill in the coupon below for additional information.

ROCHE

Roche Clinical Laboratories, Inc.  
1 Fairfield Crescent, West Caldwell, New Jersey 07006

Gentlemen:

I am interested in learning more about  
Roche Clinical Laboratories' Services.

- ☐ Please send the Roche Clinical Laboratories  
Reference Manual.
- ☐ Please have a Roche Professional Representative  
contact me.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Tel. No. \_\_\_\_\_



## DICTIONARIES WEBSTER

Library size, 1971 edition, brand new,  
still in box. Cost new: \$45.00.

**Will Sell for \$15**

Deduct 10% on orders of 6 or more.

Mail to

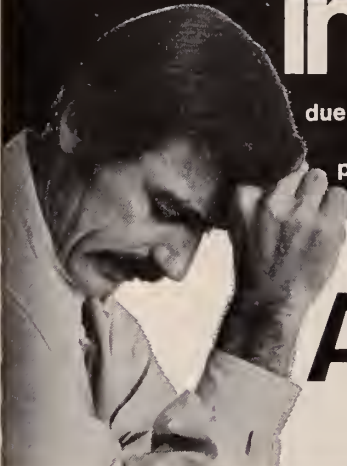
### NORTH AMERICAN LIQUIDATORS

1450 Niagara Falls Blvd.

Dept. X-2104

Tonawanda, New York 14150

C.O.D. orders enclose \$1.00 good will  
deposit. Pay balance plus C.O.D. ship-  
ping on delivery. Be satisfied on inspec-  
tion or return within 10 days for full  
refund. No dealers, each volume speci-  
fically stamped not for resale.  
Please add \$1.25 postage and handling.  
New York State residents add applicable  
sales tax.



The treatment of

# impotence

due to androgenic deficiency in the American male.

The concept of chemotherapy plus the  
physician's psychological support is confirmed  
as effective therapy.

**NEW  
CLINICAL  
STUDY**

The Treatment of Impotence  
with Methyltestosterone Thyroid  
(100 patients—Double Blind Study)  
T. Jakobovits  
Fertility and Sterility, January 1970  
Official Journal of the  
American Fertility Society



# Android®

(thyroid-androgen) tablets

**Double-Blind Study and Type of Patient:**  
100 patients suffering from impotence. Of  
the patients receiving the active medication  
(Android) a favourable response was seen  
in 78%. This compares with 40% on  
placebo. Although psychotherapy is indi-  
cated in patients suffering from functional  
impotence the concomitant role of chemo-  
therapy (Android) cannot be disputed.

**Choice of 4 strengths:**

**Android**

**HIGH POTENCY**

*Each yellow tablet contains:*  
Methyl Testosterone .25 mg.  
Thyroid Est. (1/6 gr.) .10 mg.  
Glutamic Acid .50 mg.  
Thiamine HCL .10 mg.  
Dose: 1 tablet 3 times daily.  
Available:  
Bottles of 100, 500, 1000.

**Android-HP**

**HIGH POTENCY**

*Each red tablet contains:*  
Methyl Testosterone .50 mg.  
Thyroid Est. (1/6 gr.) .30 mg.  
Glutamic Acid .50 mg.  
Thiamine HCL .10 mg.  
Dose: 1 tablet 3 times daily.  
Available:  
Bottles of 100, 500, 1000.

**Android-X**

**EXTRA HIGH POTENCY**

*Each orange tablet contains:*  
Methyl Testosterone .125 mg.  
Thyroid Est. (1 gr.) .64 mg.  
Glutamic Acid .50 mg.  
Thiamine HCL .10 mg.  
Dose: 1 or 2 tablets daily.  
Available:  
Bottles of 60, 500.

**Android-Plus**

**WITH HIGH POTENCY  
B COMPLEX AND VITAMIN C**

*Each white tablet contains:*  
Methyl Testosterone .25 mg.  
Thyroid Est. (1/6 gr.) .15 mg.  
Ascorbic Acid (Vit. C) .250 mg.  
Thiamine HCL .25 mg.  
Glutamic Acid .100 mg.  
Pyridoxine HCL .5 mg.  
Niacinamide .75 mg.  
Calcium Pantothenate .10 mg.  
Vitamin B-12 .25 mcg.  
Riboflavin .5 mg.  
Dose: 2 tablets daily.  
Available: Bottles of 60, 500.

**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montano, P., and Evangelista, F. Methyltestosterone-thyroid treatment of actual impotence. Clin Med 12:59, 1965. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:57, 1964. 3. Titen, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:5, 1952. 4. Neftman, L., Bradlow, M. L., Zeman, B., Fawcett, D. R., and Gallagher, T. F. Thyroid-androgen interactions and the hypohormonal effect of androstenedione. J Clin Endocr 19:636, 1959. 5. Farris, E. J., and Callen, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:853, 1958. 6. Olat, A., and Farrar, E. E. United States Dispensary (ed. 25). Lippincott, Philadelphia, 1955, p. 1492. 7. Warshaw, L. P. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057



# Upjohn's low-priced erythromycin



**E-Mycin<sup>®</sup>**  
(erythromycin, Upjohn)  
Available in 250 mg tablets

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2141-6

# It's about time somebody told the true story of the American Doctor.

You'd agree 100% on that. There have been too many of the other kind of story.

You know that the vast majority of American doctors are honest, hardworking, skilled and dedicated human beings who have the interests of their patients at heart.

That's exactly what the AMA is trying to make the public aware of.

One of the many ways the AMA is doing it is through its special communications program.

Perhaps you've seen pages in newspapers and national magazines signed "America's Doctors of Medicine." They're part of this program. It tells the true story of what it takes to become a doctor. The ways American medicine has improved the public's health. And to express the profession's concern about health by providing information which will help every American lead a healthier life.

We're telling this story for you, the American doctor. If we are to continue to represent you effectively, we need your support.

Find out more about what the AMA does for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

**JOIN US.  
WE CAN DO MUCH MORE TOGETHER.**

American Medical Association  
535 North Dearborn Street/Chicago, Illinois 60610



---

# DINNER DANCE

---

Mr. Richard I. Nevin, Toastmaster.

*Mr. Nevin:* Ladies and gentlemen, will you take your seats. By way of starting the evening, we have asked Doctor Watson E. Neiman to pronounce the invocation.

*Dr. Neiman:* Our Heavenly Father, we thank Thee for the privilege of having had Vernon Davis for our President during the past year. May he soon forget his frustrations and long remember the accomplishments and his many enjoyable moments.

We thank Thee for these gifts which we are about to receive through Thy bounty. Bless them to our use and us to Thy service and make us ever mindful of the needs of others.

Amen.

*Mr. Nevin:* Now, I shall ask Mrs. Donald A. McLean, President of the Woman's Auxiliary of The Medical Society of New Jersey, to bid you welcome.

*Mrs. McLean:* I do bid you welcome. This is my last task as President of the Woman's Auxiliary; and before I am relegated to the limbo of Past-Presidents, there is one little thing I would like to do, and I hope you will bear with me.

When I started to come to Trenton as County President in 1965, everybody was very friendly and said "What is your name and where are you from?" and the next question was invariably "Where is that?" So, I decided that I would be Salem County's ambassador some day. I tried very hard to do that this year. However, just in case I missed somebody, I want to show you where Salem County is. Now, there is Trenton and there is Atlantic City, and here is Salem County.

Do have a good time. Thank you.

*Mr. Nevin:* Ladies and gentlemen, go right on with your eating, but I thought you would like to know who are all these people at the head table.

To the extreme left is Doctor Emanuel Satulsky, who is enjoying a few last flings as the immediate Past-President of The Medical Society of New Jersey.

Next to him is the lady of my delight, my wife.

Next, we have a man who is assured of the best of both worlds; he is both a physician and a clergyman, Doctor Neiman.

Then, the amiable and gracious Mrs. William D'Elia, wife of the President-Elect of The Medical Society of New Jersey.

Next, we have Doctor Davis, whom I shall later try to classify for you.

Then, the sparkling and vivacious Mrs. McLean, President of the Woman's Auxiliary.

To my immediate right, the spirited and charming wife of our President, Mrs. Davis.

Next to Mrs. Davis is Doctor D'Elia, who, as far as we know, has as his chief accomplishment, so far, being the husband of Mrs. D'Elia.

Next to him is the capable, gifted and dynamic President-Elect of the Woman's Auxiliary, Mrs. Charles Gandek.

Our next guest is Doctor McLean, who is a successful physician, and happy to be Marty's husband.

Next to Doctor McLean is the lady whom I have been introduced to tonight as the beautiful and dear Mrs. Neiman.

At the extreme right is another happy gentleman, who is also a successful physician and



happy to be the husband of his wife, Doctor Gandek.

I hope I may at this interval call attention to the Fellows of the Society who are with us. Doctor and Mrs. Charles H. Calvin are at table 23, and I would like them to take a bow; Doctor John J. Bedrick is at table 32; Doctor and Mrs. John F. Kustrup are at table 22; Doctor Nicholas A. Bertha at table 10; Doctor and Mrs. Louis K. Collins at table 11.

*Dr. Collins:* Table 12.

*Mr. Nevin:* It says 11 here. You must be at the wrong table.

We have Doctor Joseph R. Jehl and Mrs. Jehl at table 12. Somebody is confused, but it cannot be my list . . . not much.

Are there any other Fellows and their lovely ladies here?

We have also as our guest tonight—and Doctor Collins and Doctor Jehl are serving as host for these guests—Doctor and Mrs. Robert I. Kaplan. Doctor Kaplan is President of the New Jersey Dental Association.

Doctor and Mrs. Sidney Grobman. Doctor Grobman is President of the New Jersey Association of Osteopathic Physicians and Surgeons.

Mrs. Miriam Harber of the American Association of Medical Assistants of the State of New Jersey; and Miss Catherine E. Denning, President of the New Jersey State Nurses' Association.

I have just a few more introductions.

Doctor Davis tells me that at table 2 his associate is here, Doctor and Mrs. Ernest Gentchos, and his assistants in the office, Mr. and Mrs. Gerald Cox. I know Mrs. Cox is in the office, but I don't think Mr. Cox is. That also goes for Mr. and Mrs. George Stout.

Thank you very much, ladies and gentlemen.

(After-dinner ceremonies.)

*Mr. Nevin:* If you are ready, ladies and gentlemen, we will go on with the program. Maybe whether you are ready or not, we will go on with the program. Well, just chew quietly and drink gently.

I know that in other years I have told you generally a rather poor joke, but tonight, because we have engaged a man at Doctor Davis' recommendation, who is going to take you "From Concert to Comedy" I decided it was the better part of discretion and valor not to compete with him.

So, I am going straight on with the program. Now we come to the point where we have to advance to presenting the Fellow's Key to our retiring President. At such times, I always impose upon you a little bit of me (and a little bit of me is still rather extensive).

There is for me always a tender melancholy attendant upon the annual Presidential dinner because even as we hail the guest of honor, we are aware that we are bidding him farewell.

Someone has said "We die a little each time we say good-bye." This is the 22nd of such little deaths that I have undergone, and I find that they do not become easier to bear. It is, at once, the reward and the penalty of this office of mine that I work for and with the President and get to know and love the man; that is what has happened again this year.

In consequence, I now regard North Carolina not as I once did, as the State in which Wilbur and Orville Wright flew the first power-driven airplane, but as the State whose place is hallowed, in my heart at least, because it gave to us and the world Vernon Davis.

Vernon is an earnest, impartial, conscientious, sincere, kindly, gentle man. There is about him a blessed and abiding serenity. Like the coastal areas of his own familiar Hatteras, he "looks on tempests and is never shaken."

He has, I think, a deep intuitive faith that despite "the element's rage and fiend voices that rave," God is in his heaven, and, in consequence, ultimately all will be right with the world.

The President leaves us, but the good man and good friend remain. I know I speak for all when I say "Thank you, Mr. President, and God keep you, Vernon, in the fullness of your attributes, as a man and a physician, for many fruitful, happy years."

And, now, as the President fades out, a new Fellow marches in. You all know about this aristocracy of the Fellowship. One has to serve through the Presidential Chairs and the Presidency to win his way into it; and at this juncture every year, as a man leaves the Presidential Office, his predecessors in the Presidential Chair induct him into the Fellows' membership.

So, I call now on Doctor Emanuel M. Satulsky, as the last gesture of his Immediate Past-Presidency—because very shortly, Vernon will be taking over that title—to induct Vernon as a Fellow of The Medical Society of New Jersey.

*Dr. Satulsky:* Mr. Toastmaster, Mr. President, Ladies and Gentlemen: On the occasion of our Annual Dinner, we must look forward and backward.

It is important to know our history; only in this way can we determine the progress that has been made or put the present into its most realistic prospective, to chart the future.

We prepare for the future with new leadership. Our strength may have been diminished, but we are flexible, and we stand ready to assume our great responsibilities.

John Galsworthy said it best: "If you do not think about the future, you cannot have one."

We are proud of our past, and tonight we honor our outgoing President, E. Vernon Da-

vis. I will ask the following Fellows, Past-Presidents of our Medical Society of New Jersey, to come forward as I call their names: Charles H. Calvin of Middlesex County, 172nd President of The Medical Society of New Jersey—I call the senior ones because it takes them longer to get up here—Doctor John J. Bedrick, Hudson County, the 173rd President of The Medical Society of New Jersey; while he is coming up, Doctor Joseph R. Jehl, Passaic County, 174th President of The Medical Society of New Jersey; Doctor Louis K. Collins of Gloucester County, the 175th President of The Medical Society of New Jersey; Doctor John F. Kustrup of Mercer County, the 176th President of The Medical Society of New Jersey; Doctor Nicholas A. Bertha of Morris County, the 177th President of The Medical Society of New Jersey.

Gentlemen, it is our responsibility to receive our President, E. Vernon Davis, M.D., the 179th President of The Medical Society of New Jersey, into our select group with the presentation of this Fellow's Key. I know you cherish your key, as much as I do mine, for what it represents—the esteem, the recognition, and the approval of our peers.

Pass this key among you; when you return it to me, it will indicate your approval and acceptance of this candidate.

By returning this to me, you have indicated your acceptance of this candidate.

Doctor Davis, it is my privilege, as the Immediate Past-President, the 178th President of The Medical Society of New Jersey, to present to you this Fellow's Key, with the approval of the Fellows assembled here. We bid you welcome.

*Mr. Nevin:* This is getting too lachrymose. So, by way of distraction for the new Fellow, we invite him to the exciting experience of pinning the Fellowette's Pin on Mrs. Donald McLean.

*Dr. Davis:* One of the last, pleasant things I have to do as President is to pin this Fel-

lowette's Pin on the Woman's Auxiliary's President. Never has such a beautiful girl ever had a pin put on her chest.

*Mr. Nevin:* That's enough of that.

Doctor Arthur C. Dietrick, President of the Burlington County Medical Society, is recognized to make a presentation.

*Dr. Dietrick:* As representative of the Burlington County Medical Society, I could offer a eulogy in tribute to E. Vernon Davis, but I will summarize by saying that to us he is our "Mr. Medical Society." We offer this gift in appreciation, as a reminder of our appreciation to him for his self-sacrifice and endeavors

in the past year.

*Dr. Davis:* To Doctor Dietrick and the members of the Burlington County Medical Society and their good wives, I thank you from the bottom of my heart.

If it had not been for you, I would have never made it up the hill, and to you all the credit is due; I am very grateful to you, as I said, from the bottom of my heart. Thank you.

*Mr. Nevin:* And, now, ladies and gentlemen, I have the pleasure of introducing Mr. Mel Ehrin, who will present "From Concert to Comedy" to entertain you.



President Davis and Mrs. Davis



Incoming President D'Elia and Mrs. D'Elia.



Executive Director Richard I. Nevin and Mrs. Nevin.





**Pink isn't exactly his color,  
but he loves it for a change.**

**WinGel<sup>®</sup>**

aluminum-magnesium hydroxides  
mint-flavored antacid liquid and tablets

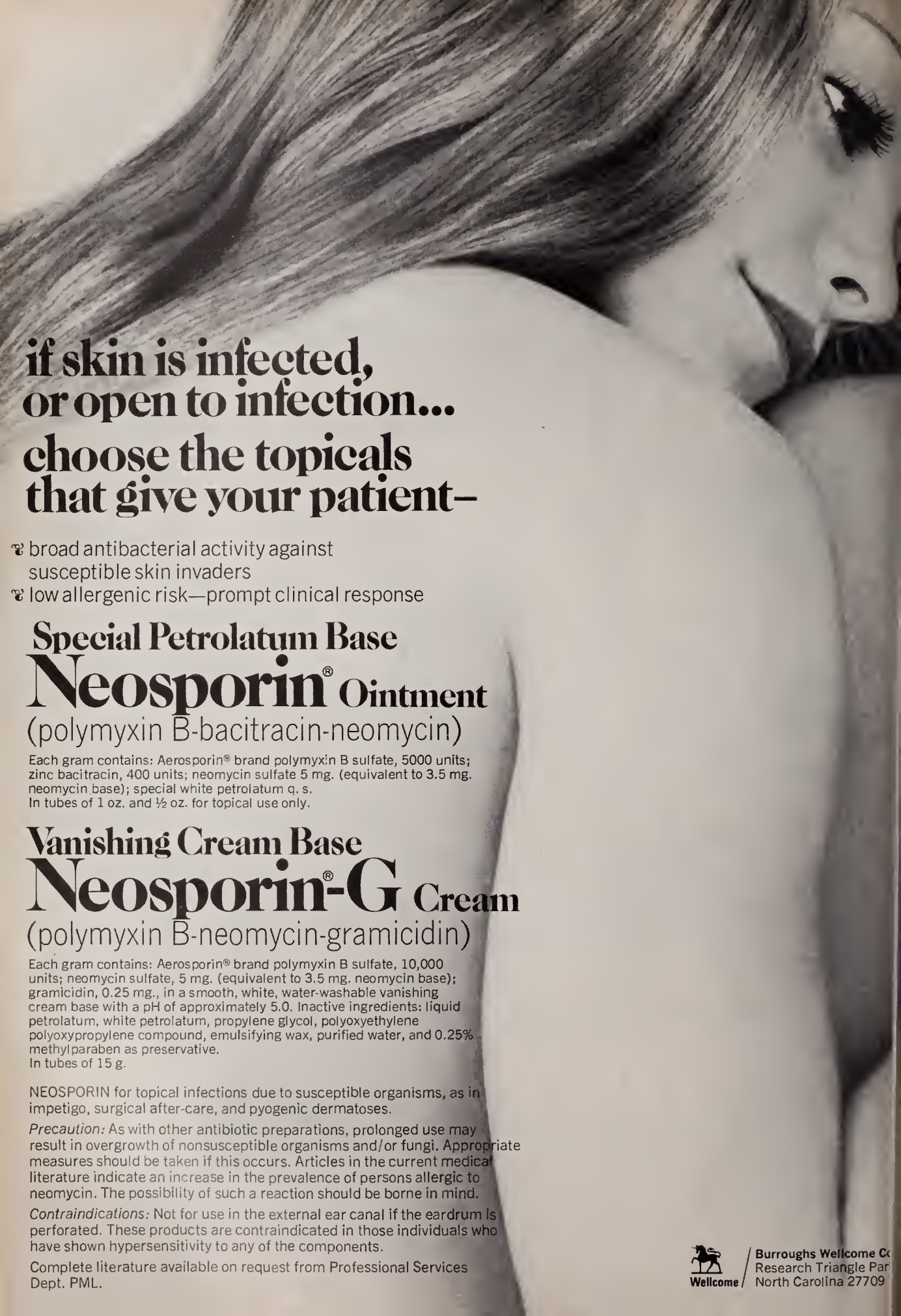
For your ulcer and ulcer-prone patients...  
a refreshing break from the  
boring sameness of white antacids.

- pleasing mint flavor
- non-gritty texture
- formulated to avoid  
constipation and laxation



**Winthrop**

WINTHROR LABORATORIES  
NEW YORK, N.Y. 10016



**if skin is infected,  
or open to infection...  
choose the topicals  
that give your patient—**

- ☞ broad antibacterial activity against susceptible skin invaders
- ☞ low allergenic risk—prompt clinical response

**Special Petrolatum Base**  
**Neosporin<sup>®</sup> Ointment**  
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

**Vanishing Cream Base**  
**Neosporin<sup>®</sup>-G Cream**  
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.  
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

**Precaution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

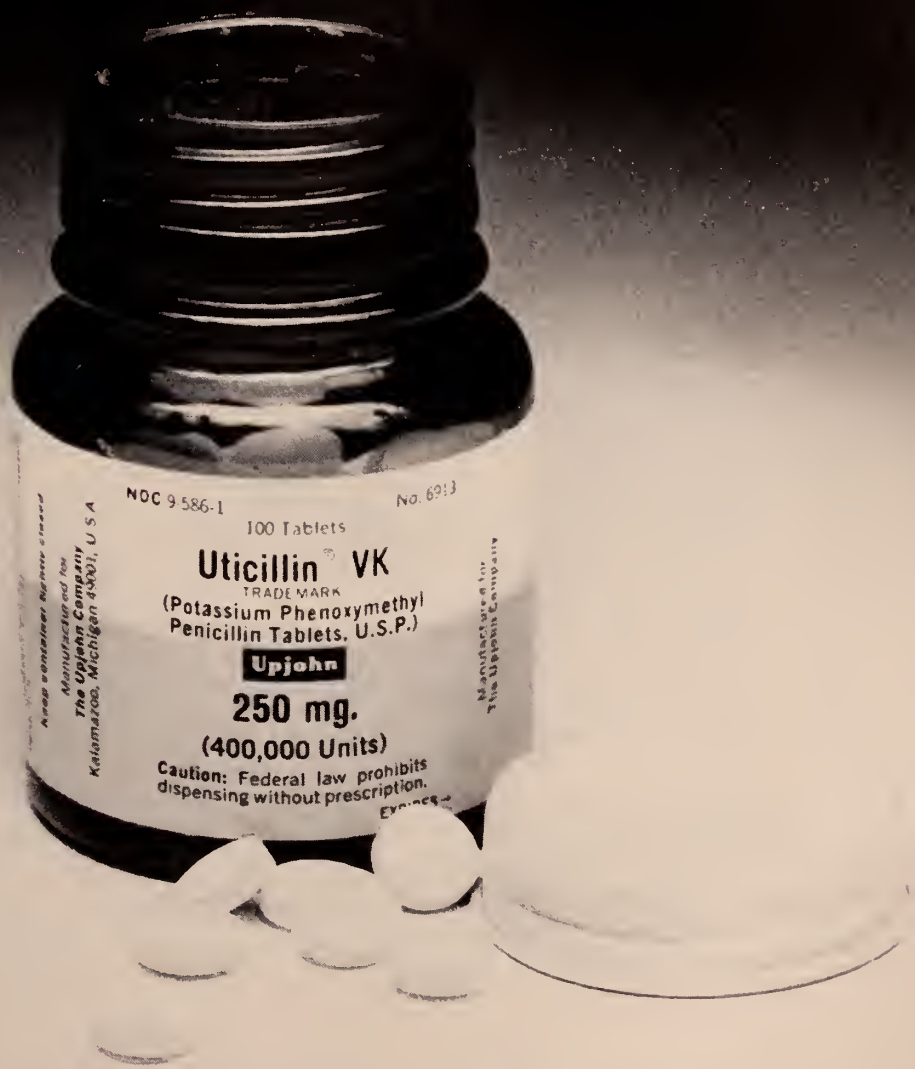
Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709



# Upjohn's low-priced penicillin VK



## Uticillin<sup>®</sup> VK

(potassium phenoxymethyl penicillin, U.S.P., Upjohn)

Available in 250 and 500 mg tablets;  
250 mg/5 ml and 125 mg/5 ml flavored granules  
for oral suspension

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2144-6



# YOU CAN MAKE A DIFFERENCE



Overcrowding, unemployment, discrimination and hunger contribute to mental illness. They also serve as barriers between the poor and proper diagnosis and effective treatment of mental illness.

The National Association for Mental Health is committed to tackling the problems of the disadvantaged, by helping them secure the benefits of advances in the prevention, diagnosis and treatment of health problems.

Your Mental Health Association is working to ensure that services for the mentally ill are provided in areas where they are needed the most.



**JOIN AND SUPPORT YOUR  
MENTAL HEALTH ASSOCIATION**

*Citizens Who DO Make A Difference*

---

# THE AUXILIARY YEAR—1971-72

---

Saturday Afternoon, May 6, 1972

*Mrs. Donald McLean:* Doctor Davis, Doctor D'Elia, members of the House of Delegates, and guests. Thank you for giving me the privilege of speaking to you today. I ask you please to listen carefully to what I have to say, as I stand before you frustrated by the problem our organization has.

Two years ago our medical advisor, in his report to you, defined an Auxiliary as the right arm of the body to which it is attached. Gentlemen, your right arm is withering and dying from lack of circulation from the body to which it is attached. In fact, in many of the counties the blood supply has been severed. In my travels through the state I heard the following remarks by auxiliary county presidents: "I called our County President three times to set up a meeting to discuss plans for the year, and he wouldn't even return my calls," or "We have been told to get together socially but keep out of community problems," and a third said, "Even though the Medical Society has asked us to make Medical Student Loan our priority, our local society forbids us to have any fund raising activities." I can't help but feel that this attitude by you is responsible for the fact that we have only 2500 members vs. your 8000.

An article was written in the *Newark Sunday News* entitled, "The Garden State Go Getters." In it, the author cites our activities and the help we have given to our communities. She also points out: doctors have an ambivalent attitude toward their wives; they trust them to raise their children and manage the household budget. Confidence? Yes, in the home. Ladies may be heroines to their husbands, she says, for their housekeeping and hostessing; but beyond the threshold doctors are skeptical of their leadership and organizational abilities in civic affairs. Collec-

tively, in the Woman's Auxiliary, they're sometimes regarded by their husbands with a "heaven help us" resignation when they "intrude" into the service programs of their medical societies. How true her statements are! And so, I make a plea to you that wives all over the world are making to their husbands: "make us feel needed."

Despite our inner struggles, we have had a fruitful year: \$12,292 was raised for AMA-ERF; \$6,000 for Medical Student Loan; \$8,000 was given in para-medical grants and scholarships. Educational material was made available to students all over New Jersey on health careers, drug abuse, and venereal disease. Burlington and Camden Counties held successful "Community Health Days" where the public was educated on resuscitation and on family planning. Warren, Hudson, and Salem Counties did testing on pre-school children for amblyopia. We have cooperated with the Cancer Society in Monmouth County to do county-wide Pap smears, and the Health Department in Salem County to do diabetes and Mantoux testing. Our members serve on boards of almost all other organizations, and gave thousands of volunteer hours. In Camden County, a clothes closet and rehabilitation program was set up to help patients discharged from mental hospitals. Drug samples were packed and sent to the missions. Foreign residents and their wives were made to feel welcome with teas, luncheons, and dinners. The members were kept aware of legislative matters and many letters were written, pro and con, to the legislators. We toured the medical school at Rutgers and Newark at the invitation of the President, Doctor Bergen.

These projects have been done willingly by our members in the belief that they are helping you, who are too busy to bother. Please let the Auxiliaries on the county level know that you are aware of their work, and are pleased with it.

# They're debating your future in Washington right now. Who's standing up for you?

National health insurance is the issue, and the way you'll practice in the future is at stake. One proposal would federalize the entire medical system.

Who's standing up for your rights? Contrary to what you may think, the AMA.

We've testified repeatedly against a government controlled medical system. Even before it was proposed, the AMA had introduced its own program of voluntary national health insurance called "Medicredit." And we've pushed for it hard. To date, the AMA has enlisted 167 members of Congress as its co-sponsors — more than can be claimed for any other national health insurance bill.

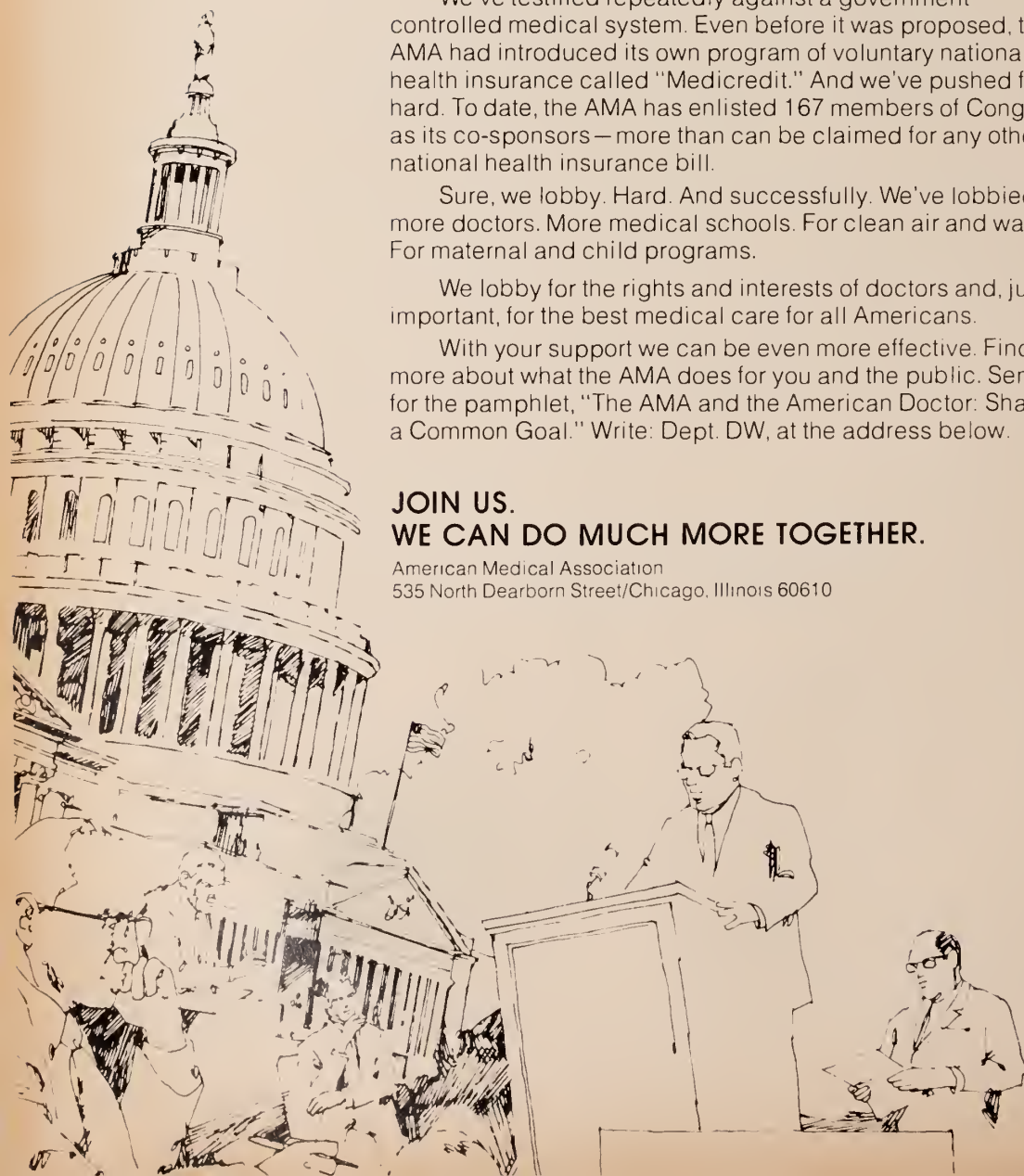
Sure, we lobby. Hard. And successfully. We've lobbied for more doctors. More medical schools. For clean air and water. For maternal and child programs.

We lobby for the rights and interests of doctors and, just as important, for the best medical care for all Americans.

With your support we can be even more effective. Find out more about what the AMA does for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

**JOIN US.  
WE CAN DO MUCH MORE TOGETHER.**

American Medical Association  
535 North Dearborn Street/Chicago, Illinois 60610





# ATTENDANCE

## REGISTRATION OF HOUSE OF DELEGATES

### Registration:

Total Possible—Officers and Fellows	24
Total Possible—County Delegates	372
Total Possible—1972 House of Delegates	396
Total Registered	365

### Attendance of County Delegates at the House Sessions:

1st Session, 5/6/72	304
2nd Session, 5/7/72	344
3rd Session 5/8/72: Part I	328
5/9/72: Part II	305
Average	320

## Official Attendance Report

County	Delegates	Members	Total
Atlantic	9	41	50
Bergen	42	49	91
Burlington	9	21	30
Camden	22	41	63
Cape May	3	3	6
Cumberland	4	7	11
Essex	65	105	170
Gloucester	4	12	16
Hudson	27	25	52
Hunterdon	3	3	6
Mercer	23	40	63
Middlesex	17	37	54
Monmouth	21	62	83
Morris	16	28	44
Ocean	6	11	17
Passaic	31	33	64
Salem	3	8	11
Somerset	6	13	19
Sussex	3	1	4
Union	30	34	64
Warren	3	3	6
Fellows and Officers	18	—	18

Physician Guests	52
Physician Exhibitors	22

TOTAL PHYSICIAN REGISTRATION 1,016

Auxiliary	413
Visitors	371
Exhibitors	253

TOTAL REGISTRATION 2,053

## FIVE YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1972	1,016	1,037	2,053
1971	966	940	1,906
1970	989	1,104	2,093
1969	1,041	1,073	2,114
1968	1,112	1,176	2,288

## **GENERAL PRACTITIONER OR INTERNIST**

Wanted for the

Medical-Surgical Section of Trenton Psychiatric Hospital. Salary range for General Practitioners \$20,731 to \$26,953; for Internists \$22,856 to \$29,714, depending on qualifications. Excellent fringe benefits. Live and work in historic Trenton. For further information, write M. H. Weinberg, M.D., Medical Director, Trenton Psychiatric Hospital, Trenton, N.J. 08625.

## **NEW JERSEY**

**FULL TIME                      PART TIME**  
**EMERGENCY ROOM**  
**VARIED SHIFTS AVAILABLE**  
**NEW JERSEY LICENSE REQUIRED**

APPLY: R. J. Matthews, Personnel Director, Point Pleasant Hospital, Osborn Avenue and River Front, Pt. Pleasant, N.J. 08742  
Phone (201) 892-1100

## **OBSTETRICIAN-GYNECOLOGIST—**

needed—ideal location for solo or group practice expanding population serviced by short term, general acute hospital. J.C.A.H. fully accredited 87 beds expanding to 125—1200 births annually in service area—South Jersey Hospital midway Philadelphia and Atlantic City—Contact Mr. Kille, Administrator, William B. Kessler Memorial Hospital—609-561-6700.

## **OPENINGS**

for  
**Full-Time Physicians**  
**Emergency Room**  
**St. Joseph's Hospital**  
**Paterson, New Jersey 07503**  
  
contact: Sister Anne Jean,  
Administrator  
(201) 684-7500

## **PART-TIME PHYSICIANS**

In Ophthalmology, Orthopedics and Urology. Excellent opportunity for retiring Physicians and recent residency graduates. Write:

**Chief, Outpatient Clinic**  
**Veterans Administration**  
**20 Washington Place**  
**Newark, N.J. 07102**

Phone: (201) 645-3430

**PHYSICIANS WANTED:** Psychiatrist—Immediate openings to work on Psychiatric Services. Also openings in community mental health clinics in need of expansion. Jersey Shore Area. Excellent personnel programs and benefits. May have part time practice. State License required. Salary to \$29,714.00 depending on qualifications. Send resume in confidence to Michael R. Simon, M.D., Medical Director, Marlboro Psychiatric Hospital, Marlboro, New Jersey. Telephone: 201-946-8100.

## **EMERGENCY ROOM PHYSICIAN**

Splendid opportunity in choice suburban location. Excellent salary in addition to a full benefit program. New Jersey license required.

Contact: Robert F. Zimmerman, M.D.  
Morristown Memorial Hospital  
Morristown, N. J. 07960  
(201) 538-4500

# CLASSIFIED ADVERTISEMENTS

**AVAILABLE**—October thru June, getting out of Army, starting residency. Need part-time work as surgery assistant, ER, general practice. H. S. Sherman, M.D., SBHAM, Fort Ord, California 93941.

**UROLOGIST WANTED**—Board certified or eligible to join 2-man certified incorporated group in North Central New Jersey, 15 minutes from New York City. Leading to full partnership in 3 to 4 years. Write Box No. 14, c/o THE JOURNAL.

**FOR SALE**—Elizabeth, New Jersey. Ranch home and 4-room office combination. Modern, excellent condition, near schools, all transportation, every modern convenience, beautiful location. Desirable for any speciality or two doctors. Write Box No. 18, c/o THE JOURNAL.

**FOR SALE**—Morris County. Exceptional opportunity for general practitioner, pedestrian, ophthalmologist and ob-gyn in new professional center. 10 minutes from 4 hospitals, highly desirable community. Write Box No. 13, c/o THE JOURNAL.

**FOR RENT**—Trenton, New Jersey. Home-office, semi-detached brick house near Mercer Hospital in professional area. Lot 50' x 300', ample parking, 3-car block garage. Prominent physician occupies home and office. 32 years. Central air conditioning, oil heat, 4 zones. Office—waiting room, consultation room, 2 examining rooms, 2 tile lavatories, large laboratory, instrument room, large closets. Over office, 5-room modern apartment. Home—8 rooms, 3 baths, ample closets. Home can be easily converted into two units. Will finance. Write Box No. 10, c/o THE JOURNAL.

**FOR RENT**—Jersey Shore, 8 room office. Approximately 1200 square feet. Any specialty or general practice. Area needs physicians. Assume my lease for \$350.00 monthly. Available July 1, 1972; 15 minutes from 2 hospitals. One hour from New York City and Philadelphia. R. A. Daniels, M.D., 200 Norwood Avenue, Box 356, Elberon, New Jersey 07740. Phone. (201) 22-7757.

**SPACE AVAILABLE**—Woodbridge, New Jersey. Highway 35, Amboy Avenue, 700 to 2000 square feet in modern one-story medical specialty building. Central heating and air conditioning, ample off-street parking. Call (201) 634-4225.

**Information for Advertisers—RATES:**—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifth of preceding month.

## COLLECTIONS HENRY-LESLIE ASSOCIATES

"BONDED"  
P.O. BOX A  
CRANBURY, N. J. 08512  
(609) 395-1760

P.O. BOX 905  
TOMS RIVER, N.J. 08753  
(201) 244-2502

*Professional Services for the Health Professions*  
**NO CHARGE UNLESS WE COLLECT**

## PROFESSIONAL OFFICES AVAILABLE

Fantastic opportunity for Doctors to establish medical practice.

Morganville, New Jersey, in northern Monmouth County is in need of Doctors now. Population increasing rapidly. For information write:

**Rappa Bros., Inc.**  
5 Union Avenue  
Morganville, N.J. 07751

or call:  
(201) 536-9054 or (201) 591-1967

## RENT

New 8200 Sq. Ft. Professional Building  
Will Divide—Ideally suited for Physician  
34 car parking

Haddonfield-Berlin Road  
Cherry Hill, New Jersey  
(Between Brace Road & Route 295)

Minutes to Haddonfield & Voorhees Township  
Immediate occupancy available  
Call (609) 966-6061



TEMPLE UNIVERSITY HEALTH SCIENCES CENTER presents the 16th Annual Postgraduate Course, Recent Advances in Medicine, on 8 consecutive Wednesday's from October 18 to December 6, 1972 from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand Rounds, Clinics, Case Discussions, Office Procedures, Lectures, Panel Discussions, Luncheon with the Experts, all with audience participation.

Faculty: Members of the Department of Medicine and other selected Departments of Temple University Health Sciences Center.

Guest Faculty:

Grant Liddle, M.D.  
Professor and Chairman,  
Department of Medicine  
Vanderbilt University School of Medicine  
Nashville, Tenn.

Frank A. Finnerty, Jr., M.D.  
Professor of Medicine  
Georgetown University Medical Center  
Washington, D. C.

Henry D. McIntosh, M.D.  
Professor and Chairman,  
Department of Medicine  
Baylor University School of Medicine  
Houston, Texas

James L. Quinn, III, M.D.  
Professor of Radiology  
Northwestern University Medical School  
Chicago, Ill.

A.A.G.P. Credit Requested

For further information and Curriculum: Department of Medicine  
Temple University Health Sciences Center  
3401 North Broad Street  
Philadelphia, Pennsylvania 19140  
Sol Sherry, M.D.  
Chairman, Department of Medicine  
Albert J. Finestone, M.D.  
Director of Course

## THE MEDICAL SOCIETY OF NEW JERSEY

### Professional Liability Insurance Program

Society Endorsed Coverages—

- Professional Liability for  
Individuals  
Partnerships and Professional Corporations  
Employed Nurses, Technicians or Aides
- Professional Premises
- Excess (Umbrella) Liability—Limits up to \$5 Million

Management of Loss Control Program—

- Claims Peer Review
- Prompt Advice Regarding Potential or Actual Claims
- Defense by Highly Skilled and Experienced Counsel
- Investigation by Specialists in Malpractice

## JOSEPH A. BRITTON AGENCY

15 South Munn Ave., East Orange, N.J. 07018

(201) • 673-3060

**POSTGRADUATE COURSE FOR PHYSICIANS**

**RECENT ADVANCES IN INTERNAL MEDICINE AND THERAPEUTICS**

(Seventeenth Series)

sponsored by

The New Jersey State and Middlesex County Chapters of the American Academy of Family Physicians, the Academy of Medicine of New Jersey, and Middlesex General Hospital, New Brunswick.

Meeting Place: Auditorium, Middlesex General Hospital, 180 Somerset Street, New Brunswick, New Jersey.

Time: Wednesdays, 9 to 11 a.m. starting September 20, 1972.

Beginning this September and ending the last Wednesday in May, 1973, the Seventeenth Postgraduate Course "Recent Advances in Internal Medicine and Therapeutics" will be given at Middlesex General Hospital in New Brunswick. As in previous years, the Course is designed to provide clear and concise reviews of important new advances in internal medicine which are of practical interest to internists and general practitioners. The Course provides university credit toward meeting the requirements of the AAFP (totaling 72 points for the 36 sessions).

All 36 of the two-hour Wednesday morning sessions are conducted by outstanding physicians of the medical faculties of New York, Philadelphia, Boston and other metropolitan centers. During the sessions opportunity is given to discuss with the speakers aspects of clinical problems which arise in the care of individual patients.

The 1972-1973 Course will be divided into sections dealing chiefly with Gastroenterology, Drug and Antibiotic Therapy, Renal Disorders, Neurology, Psychiatry, Psychosexual Development, Nutrition, Pain Therapy and other practical subjects.

The opening session is set for Wednesday, September 20, 1972. IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM IT IS IMPORTANT THAT YOU WRITE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE, DR. S.E. MOOLTEN, MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK, NEW JERSEY. The fee for the entire Course (34 sessions) is \$200 (for interns and residents \$60).

THE ACADEMY OF MEDICINE OF NEW JERSEY

Leo H. Siegel, M.D., President

Date: July 1, 1972

# Will his return to work mean the return of undue psychic tension?



When it's mandatory to keep the post-coronary patient calm, consider Valium (diazepam).

Although he's promised to take it easy back on the job, you know he's going back to the same stressful circumstances that may have contributed to his hospitalization. If he experiences excessive anxiety and tension because of overreaction to stress, your prescription for Valium can bring relief. During the period of readjustment Valium can quiet undue anxiety.

For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *b.i.d.* to *q.i.d.* can usually provide reliable relief. For severe tension/anxiety

states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

## Valium® (diazepam)

For the tense cardiac patient who must be kept calm

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for beneficial effect. **Adults:** Te and psychoneurotic states, *b.i.d.* to *q.i.d.*; alcoholism, 1 or *q.i.d.* in first 24 hours, then *q.i.d.* as needed; adjunct skeletal muscle spasm, 2 to 4 or *q.i.d.*; adjunctively in convulsions, 2 to 10 mg *b.i.d.* to *q.i.d.* (See Precautions.) **Geriatric or debilitated patients:** 2½ mg, 1 or 2 times daily increasing as needed and tolerated. (See Precautions.) **Children:** *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg of 100 and 500. All strengths available in Tel-E-Dose® *p.* of 1000.

ROCHE

Roche Laboratories  
Division of Hoffmann  
Nutley, N.J. 07110

LIBRARY  
JUL 11 1972  
NEW YORK ACADEMY  
OF MEDICINE

Library,  
New York Academy of Medicine  
2 East 103rd Street



BALCONY

the

# JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

---

## contents

Pages 629 to 708



### EDITORIALS

Someone Should Tell the FDA	639
Farewell to Fahrenheit	639
Health Care Is Not Just Medical Care	640
Home As the Place To Die	640

### ORIGINAL ARTICLES

Pulmonary Edema: Biochemical Disorder and Management Revisited	641
Pablo A. Catangay, M.D., Paramus	
Sella Turcica in the Mentally Retarded	647
Manuel M. Villaverde, M.D. and Jacyntho DaSilva, M.D., Woodbridge	
Hernia Repair Without Disability	651
Richard A. Raffman, M.D., Madison	
Bradycardia-Tachycardia Syndrome	659
Martin B. Wartenberg, M.D. and William F. Haynes, Jr., M.D., Princeton	
Suicide	665
David Lester, Ph.D., Pomona	
Sialographic Evaluation of Parotid and Submandibular Masses	671
Daniel S. Cukier, M.D., Hackensack	
Ophthalmia Neonatorum Is Still With Us	679
Norman W. Zanger, M.D. and Richard Chopin, M.D., Newark	
Hand, Foot, and Mouth Disease	683
Richard R. Gove, M.D., Brant Beach	

### SPECIAL ARTICLE

A Medical Diploma of 1820	684
Morris H. Saffron, M.D., Passaic	

### NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes: May 5, 1972; May 9, 1972	687
Medical College Notes	690
Communicable Diseases in New Jersey	693
New Physician Education Coordinator	694
Physicians Seeking Location in New Jersey	695

### ANNOUNCEMENTS

### LETTERS TO THE JOURNAL

### OBITUARIES

### BOOK REVIEWS

696
698
700
703

AUGUST 1972  
VOL. 69, NO. 3

# THE MEDICAL SOCIETY OF NEW JERSEY

## Endorsed Insurance Plans

### ACCIDENT AND HEALTH INSURANCE

- \$1,200** a month maximum BASIC total disability benefit.  
Accident: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
- ↓
- PLUS** Sickness: from 8th day, up to 2 years  
Accident: may be EXTENDED to Lifetime  
Sickness: may be EXTENDED to 7 years
- ↓
- \$1,000** a month maximum NEW LONG-TERM PLAN.  
Payable up to Lifetime for accident — Age 65 for sickness  
Choice of waiting periods:  
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

### ★ ★ ★ LIFE INSURANCE

- \$10,000 to \$150,000** of Convertible Term Life Insurance  
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)
- \$10,000 to \$50,000** of Convertible Term Life Insurance  
available for spouse, dependent children and employees.

### ★ ★ ★ MAJOR EXPENSE INSURANCE

- \$25,000** maximum for Covered Expenses as stated in the policy for each accident or sickness, covering member, spouse, and eligible children. \$750 deductible, 20% co-insurance. (Physicians' and surgeons' fees are not a Covered Expense.)

### ★ ★ ★ HOSPITAL-MONEY PLAN

- \$20-\$30-\$40** per day paid for each day that you or your dependents are hospitalized, from the first day for as long as 365 days for any one accident or sickness. Benefits are tax-free.

### ★ ★ ★ SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

- \$200,000** maximum for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance. \$100,000 maximum for spouse (without disability benefit).

★ ★ ★

H.R. 10 (KEOGH) RETIREMENT PLAN ★ ★ CORPORATE MASTER PLAN

#### APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected or have applied for membership.

*Information and claim service are as close as your telephone.*

**E. & W. BLANKSTEEN AGENCY, INC.**

75 MONTGOMERY STREET, JERSEY CITY, NEW JERSEY 07302

(201) DElaware 3-4340

So much goes into making  
**LAKE NAOMI**  
the Poconos' incomparable  
leisure-home community



take for example our new  
**SWIMMING POOL COMPLEX**

The BIG private lake of the Pocono Mountains, Lake Naomi, each year moves further beyond comparison among the area's most inviting leisure-home communities by adding new recreational facilities and unique community advantages. Last year, it was a 75' x 165' heated Olympic-size swimming pool, complete with diving well, wading pool and poolside pavilion. This year we're putting finishing touches to two outstanding new facilities. One is a Tennis Club complex with eight tournament-caliber clay courts and its own clubhouse. Another is a full-featured Youth

Activities Center, focal point of a diversified recreational counseling program.

Rounding out Lake Naomi's many special attractions are the Naomi Clubhouse with cocktail lounge and dining room overlooking the Lake . . . six sand beaches with lifeguards . . . great golf, fishing, horseback riding and skiing practically at your doorstep . . . finest all-weather paved roads . . . property patrolled year 'round by Lake Naomi's Ranger . . . quality-built custom houses . . . financing arranged.

**COME SEE WHY SO MANY PHYSICIANS** build at Lake Naomi. Bring your family and **BE OUR GUESTS FOR LUNCHEON AND A SWIM.** No obligation on your part. Simply tell us the date—phone collect 717-646-2222.

**LAKE NAOMI**

Pocono Pines • The Poconos • Pennsylvania





**Ampicillin, Carbenicillin, Oxacillin...**

# IMAGINE YOUR PRACTICE WITHOUT THEM

In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

Need we say more?

Prescribe the discoverer's brands:

**Totacillin<sup>®</sup>** (ampicillin trihydrate)

**Pyopen<sup>®</sup>** (disodium carbenicillin)

**Bactocill<sup>®</sup>** (sodium oxacillin)

and more to come

**Beecham-Massengill  
Pharmaceuticals **BMP****

Div. of Beecham Inc. Bristol, Tennessee 37620

- ☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.
- ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
- ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

Announcing—  
a new commitment to health care

# Roche Clinical Laboratories

Professional  
Consultation

An Advanced  
Diagnostic Center for  
Standard, Endocrine  
and Special Laboratory  
Tests

Computerized  
Quality Control  
to prevent error

Automated Diagnostic Analysis  
for most tests

A Unique Professional  
Staff of Research  
Scientists and Practicing  
Clinicians

Personal Service through Roche Professional Representatives.

The Roche Professional Representative welcomes the opportunity to introduce our laboratory service to you.  
Please fill in the coupon below for additional information.

ROCHE

Roche Clinical Laboratories, Inc.  
1 Fairfield Crescent, West Caldwell, New Jersey 07006

Gentlemen:  
I am interested in learning more about  
Roche Clinical Laboratories' Services

☐ Please send the Roche Clinical Laboratories  
Reference Manual.

☐ Please have a Roche Professional Representative  
contact me

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Tel No \_\_\_\_\_



# THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

## Officers and Trustees

### PRESIDENT

William J. D'Elia, M.D. (Monmouth) ..... Neptune City

### PRESIDENT-ELECT

Matthew E. Boylan, M.D. (Hudson) ..... Jersey City

### FIRST VICE-PRESIDENT

James A. Rogers, M.D. (Passaic) ..... Paterson

### SECOND VICE-PRESIDENT

John J. McGuire, M.D. (Essex) ..... Newark

### IMMEDIATE PAST-PRESIDENT

E. Vernon Davis, M.D. (Burlington) ..... Mount Holly

### SECRETARY

Louis F. Albright, M.D. (Monmouth) ..... Spring Lake

### TREASURER

Samuel J. Lloyd, M.D. (Mercer) ..... Trenton

## Trustees

### CHAIRMAN

A Guy Campo, M.D. (1973) (Gloucester) ..... Westville

### SECRETARY

David Eckstein, M.D. (1975) (Mercer) ..... Trenton

Robert C. Anderson, M.D. (1975) (Essex) ..... Newark

Francis J. Benz, M.D. (1973) (Morris) ..... Chatham

George L. Benz, M.D. (1974) (Essex) ..... Newark

Edward J. Bourns, M.D. (1975) (Union) ..... Westfield

Harold L. Colburn, Jr., M.D. (1973) (Burlington) ..... Mount Holly

Charles L. Cuniff, M.D. (1975) (Hudson) ..... Jersey City

Richard E. Lang, M.D. (1975) (Passaic) ..... Passaic

Nicholas E. Marchione, M.D. (1974) (Cumberland) ..... Vineland

I. Edward Ornaf, M.D. (1975) (Camden) ..... Camden

Howard D. Slobodien, M.D. (1975) (Middlesex) ..... Perth Amboy

James S. Todd, M.D. (1974) (Bergen) ..... Ridgewood

## Councilors

### FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Thomas S. P. Fitch, M.D. ..... Plainfield (1975)

### SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

John L. Olpp, M.D. ..... Englewood (1974)

### THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. ..... Trenton (1973)

### FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. ..... Haddonfield (1975)

### FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

John S. Madara, M.D. ..... Salem (1974)

## AMA Delegates

Joseph P. Donnelly, M.D. (1973) ..... Jersey City

Frank J. Hughes, M.D. (1974) ..... Gloucester

John E. Kustrup, M.D. (1974) ..... Trenton

Luke A. Mulligan, M.D. (1974) ..... Leonia

Isaac N. Patterson, M.D. (1973) ..... Westville

Emanuel M. Satulsky, M.D. (1974) ..... Elizabeth



August 1972

## Publication Committee

Daniel B. Roth, M.D., *Chairman*  
Arthur Krosnick, M.D.  
John F. Marshall, M.D.

## Editor

Henry A. Davidson, M.D.

## Assistant Editor

Marjorie D. Treptow

## Advertising Manager

Joseph W. Cookson

## Executive Director

Richard I. Nevin

*The Journal* is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 816.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription (\$3.50) is included in the dues of Society members.

Subscription rates for nonmembers: \$7 per year (including postage), in advance. Outside USA, postage is additional.

Single copies are \$1.00 each.

Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

Second class postage paid at Trenton, New Jersey, and additional entry office.

Copyright 1972 by The Medical Society of New Jersey.





## rheumatoid arthritic blowup ...

# Tandearil® Geigy

oxyphenbutazone NF tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is

unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal

distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B) 98-146-800-E

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardley, New York 10502

# BECAUSE ALLERGIES ARE A YEAR-ROUND THING.

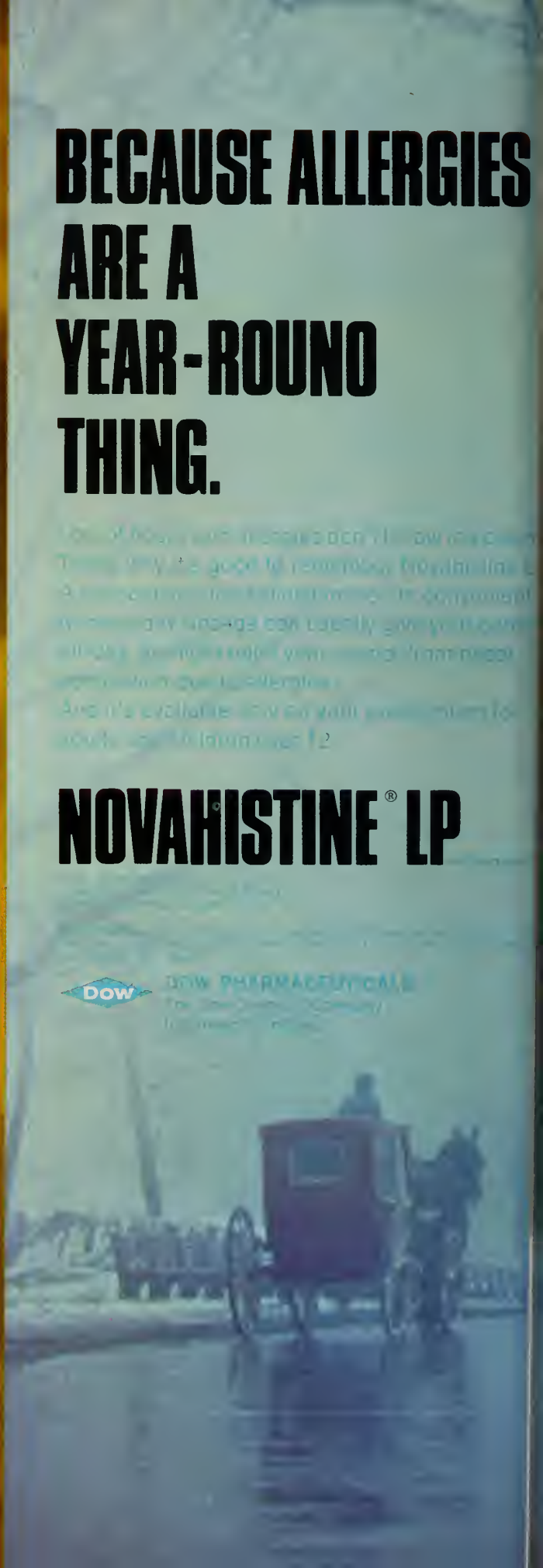
Most of today's antihistamines don't allow you to drive. That's why it's good to remember, Novahistine L.P. is a non-sedating antihistamine. In comparison, with many antihistamines you usually give your driver's license, you're asked your mind from road. Novahistine L.P. is different.

And it's available now in your pharmacy for adults and children over 12.

## NOVAHISTINE<sup>®</sup> LP



DOW PHARMACEUTICALS  
The Dow Chemical Company  
Parsippany, NJ 07054



*"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*— George Sarton, from "The History of Medicine Versus the History of Art"*

**Would it be useful  
in clinical practice to have  
government predetermine  
drugs of choice?**

# Opinion

**Results of a survey of physicians:**

**13.3%**

**Yes, it would be useful.**

**86.7%**

**No, it would not be useful.**

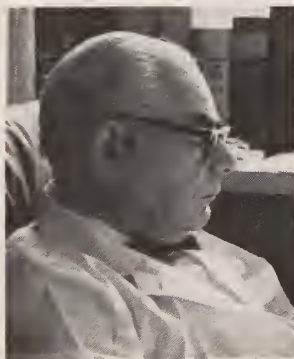


# Dialogue

## Would it be useful in clinical practice to have government predetermine drugs of choice?

### Doctor of Medicine

Walter Modell, M.D.,  
Professor of Pharmacology,  
Cornell University  
Medical College,  
Editor,  
Clinical Pharmacology  
& Therapeutics,  
Drugs of Choice,  
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial dif-

ferences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain

segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy

in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excess numbers of drugs in some therapeutic categories. As I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the "drug of choice" in areas of medical practice.

## Maker of Medicine

Nath G. Kohlstaedt, M.D.,  
Vice President,  
Medical Research,  
Eli Lilly and Company



In my opinion, it is not the function of any government or private regulatory agency to designate a "drug of choice." This determination should be made by the physician after he has received full information on the properties of a drug, and then it will be based on his experience with this drug and his knowledge of the individual patient who is seeking treatment. If an evaluation of comparative efficacy were to be made, particularly by government, at the time a new drug is being approved for marketing, it would be a disservice to medicine and thus to the patient and the consumer. For example, when a new therapeutic agent is introduced, on the basis of limited knowledge, it may be considered to be more potent, more effective, or safer than products already on the market. Conceivably, at some time the new drug would be labeled "the drug of choice." But as additional clinical experience is accumulated, new evidence may become available. Then, it may be apparent

that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B<sub>12</sub> as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. How-

ever, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "drugs of choice" is to be avoided.

## Opinion & Dialogue

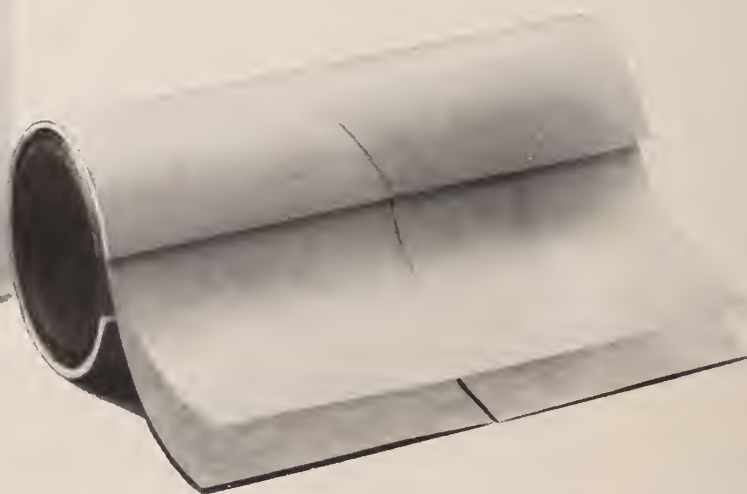
What is your opinion, doctor?

Send us your comments on the above issue.



The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005

# One of the familiar line of Cordran<sup>®</sup> flurandrenolide products



*Additional information  
available to the  
profession on request.*

200 469



Eli Lilly and Company  
Indianapolis, Indiana 46206



---

# EDITORIALS

---

## Someone Should Tell the FDA

As a result of a clinical investigation which found that several preparations of digoxin varied markedly in bioavailability (even though they were all equal by USP standards), the Food and Drug Administration will run tests on digoxin products for biologic equivalence.

Last year, clinicians at Columbia University's College of Physicians analyzed four lots of digoxin because of observations that patients were responding atypically to carefully planned therapeutic schedules. The four lots of tablets were found to be chemically equal and within USP requirements. However, when administered to normal volunteers the serum levels were found to vary markedly. In one instance the serum level was seven times that obtained for one of the other products. Several of the patients had low serum levels of the drug even though they received as much as 1.0 milligrams daily. The clinicians recommended that evidence of biologic equivalency of digoxin products should be required in addition to chemical equivalence.

This clinical report has prompted a natural and reasonable response by the FDA—tests will be run on some digoxin products for biologic equivalence. However, other responses from the FDA have not always been so rational. One is that, while there is need to inquire into bioavailability, the across-the-board requirement of biologic equivalence is too knotty for immediate official action. Another is the FDA announcement that chemical analyses have shown that some batches of digoxin showed variations of from 60 per cent to 200 per cent of the declared amount of the active ingredient. And there is the FDA statement that biologic equivalence is considered, by some, to be a "minor" problem, by others a

major consideration, and that FDA just does not presume to have the final answers.

There is also the question that one FDA official asks, "At what point do you stop applying the principle of requiring bioequivalence in drugs?" This seems a rather useless worry when it is considered that FDA hasn't even started applying the principle as yet. Someone should tell FDA that digitalis preparations would be a good place to start.

For a drug for which the proper therapeutic serum level is narrow and is balanced between a practically ineffective level when too low or a toxic effect when too high, and where individual patient tolerances, and the effects of concomitant medication introduce significant variables it is folly to work with a formulation entirely bereft of either chemical or biologic equivalence, and even worse without both.

Perhaps the FDA has been so busy eliminating time-tested pharmaceuticals from the market that it has neglected to require that potent drugs like digitalis be manufactured in reliable form.

---

*From the February 1972 issue, Journal of the Indiana State Medical Association.*

## Farewell to Fahrenheit

Effective January next, all AMA publications will list patients' temperatures in centigrade (they prefer to call it Celsius) degrees. Thus the normal temperature will be 37. Those of us who were graduated from medical school before 1940 (or maybe 1950) will have some difficulty in reacting to a nurse's report that the patient's temperature is now 39.5. We'll have to look (perhaps surreptitiously) at a conversion table to find out how sick he is. Actually it's 103.1. And in an AMA publication, the article will simply say that the temperature is 39.5 and no nonsense about adding 103.1 in parentheses. Presumably, glass graduates will have to be calibrated in milliliters, not ounces. And they won't accept cubic

centimeter either, because a milliliter is not one cubic centimeter, but rather 1.00003 cubic centimeters. (That's right: four zeros after the decimal point.) The basic unit, the meter, was once defined as a ten millionth of a meridional quadrant of the earth. Refined measurements soon indicated that this was somewhat in error, so the present definition of a meter is 1650763.73 wave lengths in vacuum of the radiation corresponding to the transition between the levels  $2p_{10}$  and  $5d_5$  of the krypton 86 atom.\* See how easy it is! Even the gram, strictly speaking, should be the millikilogram which, though it sounds like a thousandth of a thousand grams, is apparently different.\*

The spectrum of usable drugs, if you are so old-fashioned as to use the apothecary's system, is from 1/150th of a grain to 5 grains, with one grain nicely in the middle. The same values in the new system will be from 0.0004 to 0.3 Gram which, it seems to us, invites error in counting the number of zeros. Time was when you spoke of a grain of medicine, a grain of gold, and even a grain of common sense. But we must not stall the wheels of progress.

## Health Care Is Not Just Medical Care

While the physician's role in health care is obvious, there is more to it than that. To preserve a people's health, something has to be done about good housing, assurance of a pure water supply, developing non-toxic paints, sound food-processing methods, higher educational standards, poison control, traffic safety, and lots of other measures.

By and large, these are not areas in which the physician has much expertise or authority. In a sense (though this seems like an odd way of putting it) strictly *medical* (or surgical) care begins when health care has failed. And when

it comes to optimizing these other health-protective measures, we can't do it alone. Actually, health care is part of a whole social fabric, of which the services of physicians are indispensable—but not, themselves, guarantees of total health care.

So, when the community looks around for someone to blame for breakdowns in health care, let it be remembered that while the doctor of medicine may be in at the end of the line, he is not usually in at the beginning of the process which leads to total health care.

## Home as the Place To Die

We usually think of death as only the end point of serious illness, and of the hospital as the place to go when seriously sick. Perhaps we have not given enough thought to the advantages of home as the place to die. It would avoid the gruesome experience of having relatives expose their grief in hospital corridors. It would enable both the patient and the family to brace themselves for the inevitable end. It would avoid the feeling on the part of the dying patient that he is being abandoned or deserted.

True, it would mean a loss of the heroic and often spectacular last minutes emergency methods, and perhaps this might sometimes shorten the patient's life a bit. But he might gain more than he loses in the quality of his remaining days. And an incidental benefit would be the reduction of the financial burden on the family, at a time when the finances are not being thought of but may be of major importance to the survivors. Death-bed scenes are never satisfactory, but a terminus at home may mean dying with more dignity than is possible with tubes and catheters in every orifice—dying surrounded by loved ones, passing out with a sense that one has not, after all, been consigned to the care of strange attendants. Perhaps we should aim at the development of better home-care units for patients in terminal illness.

\* Vewter, S. M. and DeForest, R. E.: *JAMA*, 218:723 (November 1, 1971)

# ORIGINAL ARTICLES

*Offered here is a practical manual on handling pulmonary edema.*

## Pulmonary Edema: Biochemical Disorder and Management Revisited

**Pablo A. Catangay, M.D./Paramus\***

Pulmonary edema is a state of the lungs characterized by filling of the alveolar and many of the bronchial spaces with serous or serosanguinous fluid. This is brought about by: (1) increased pulmonary transcapillary pressure gradient, (2) decreased lymphatic reabsorption of pulmonary fluid, (3) increased pulmonary capillary permeability and, (4) decreased colloid osmotic pressure of the blood. Many conditions<sup>1 to 12</sup> are known to produce pulmonary edema, but in most instances, it is due to left ventricular failure. This paper will review some of the associated biochemical disorders which accompany pulmonary edema and will suggest certain modifications in the traditional therapy of pulmonary edema.

The significance of acid-base disturbance in acute pulmonary edema has been recognized only recently<sup>13 to 16</sup> although respiratory acidosis as a terminal finding in prolonged pulmonary edema has occasionally been described.<sup>17, 18</sup> Hyperventilation manifested by a low arterial carbon dioxide pressure ( $PCO_2$ ) is a common feature of pulmonary congestion.<sup>19</sup> This is also commonly the case in frank pulmonary edema, when significant lowering of arterial oxygen saturation may also be presented.<sup>20</sup> In 1965, Anthonisen and Smith<sup>13</sup> reported four cases of respiratory acidosis in pulmonary edema with arterial carbon dioxide ( $PCO_2$ ) as high as 120 millimeters of mercury. Agostoni<sup>14</sup> demonstrated combined metabolic and respiratory acidosis in six pa-

tients. In this group, lactate and pyruvate were elevated as well as the  $PCO_2$ . Accumulation of lactate may be observed in shock,<sup>21</sup> but none of these patients was in clinical shock.

A retrospective study of 292 patients<sup>15</sup> reviewed the frequency, severity, and type of acid-base abnormalities. In 101 cardiac cases without prior cardiac arrest or cardiogenic shock, arterial blood gas analysis was available. In this group of patients, a combined severe metabolic and respiratory acidosis was present in 55 with mean  $pH = 7.11$ ,  $PCO_2 = 70$  and base excess of minus 10 mEq. per liter. Fourteen patients had metabolic acidosis, twelve had respiratory acidosis, and eight had respiratory alkalosis. Miller, *et al.*<sup>16</sup> reported thirteen patients with acute cardiogenic pulmonary edema. In ten of these patients acute, reversible respiratory acidosis was present. Although four of the ten patients had a history of chronic bronchitis and one had pulmonary tuberculosis which might have contributed to alveolar hypoventilation and respiratory acidosis, none of the patients had pulmonary insufficiency before or after the episodes of acute pulmonary edema. Moreover, the rapid clearing of the respiratory acidosis, occurring within hours, is not typical of pulmonary insufficiency secondary to obstructive airway disease.

\*The author is Director of the Pulmonary Function Laboratory and of Inhalation Therapy at the Bergen Pines County Hospital, Paramus, New Jersey. Thanks are expressed to Dr. Leonard Lyon for his critical review of the manuscript and to Miss Constance L. Lorenz for secretarial assistance.



## Mechanisms of Acid-Base Derangement

*Respiratory Acidosis*—This implies that the respiratory system is unable to maintain an alveolar ventilation capable of coping with the amount of carbon dioxide being produced by the body.<sup>22</sup> Thus, the amount of oxygen added to the arterial blood and carbon dioxide eliminated is reduced, with resultant hypoxia, hypercapnia, and high hydrogen ion concentration (low pH). The important pathophysiologic lesions in pulmonary edema appear to be collapse and the obstruction of gas exchange units.<sup>23-25</sup> A major cause of such obstruction may be foam.<sup>26</sup> Because of the low surface tension in lung lining material, pulmonary edema bubbles form and migrate to the large airways, and can, by virtue of their stability, completely occlude these airways. Obstructed areas continue to be perfused, and constitute a veno-arterial shunt with resultant oxygen desaturation. Whether or not carbon dioxide retention ensues depends on the number and function of the remaining units. If perfusion is not maintained in units that are ventilated, carbon dioxide retention may ensue in spite of an apparently normal minute volume of ventilation. Whether this kind of ventilation-perfusion imbalance exists in human pulmonary edema is unknown and extremely difficult to assess.

The alveolar hypoventilation occurring in pulmonary edema may be related to changes in lung mechanics. Pulmonary congestion with orthopnea has been associated with increased airway resistance, due to congestion of bronchial mucosa and narrowing of the airways with frothy fluid.<sup>27</sup> Pulmonary compliance is markedly reduced in pulmonary edema,<sup>28</sup> and the work of breathing is increased on this basis as well as on the increased airway resistance. The presence of respiratory acidosis complicating pulmonary edema contributes to the magnitude of the medical emergency at hand. The mortality is 40 per cent<sup>15</sup> despite the life saving effect of assisted ventilation. Previous experimental work<sup>29</sup> had indicated that hypercapnia is a strong stimulus to the sympathicoadrenal system, with consequent elevation of the

peripheral resistance. This was supported by the work of Caress, *et al.*<sup>30</sup> who also demonstrated significant impairment of myocardial contractility. The consequences of acute hypercapnia and acidemia are pulmonary hypertension<sup>31-32</sup> and disordered cerebral function.<sup>33</sup> Acidemia at certain critical levels and hypercapnia are cellular depressant, upsetting further the control of respiration. Symptoms of hypercapnia are cerebro-vascular distention, increased cerebral blood flow, and papilledema. Signs which point to acidemia due to hypercapnia are confusion, confabulation and other personality changes, asterixis, and stupor and coma which are late signs and often are irreversible. To confirm the diagnosis, the following criteria for arterial blood gases may be used: Arterial carbon dioxide pressure ( $PCO_2$ ) = 50 mm. of mercury or more, and an arterial oxygen tension ( $PO_2$ ) of less than 50.

*Metabolic Acidosis*—Metabolic acidosis caused by lactate accumulation in the blood during hypoxia is well recognized.<sup>21</sup> Anthonisen and Smith,<sup>13</sup> and Agostoni<sup>14</sup> postulated that severe metabolic acidosis observed in acute pulmonary edema is probably produced by a marked reduction of splanchnic and muscle blood flow associated with high degree of hypoxemia. This metabolic derangement has been shown to occur in acute myocardial infarction and appeared to be more severe and more common in patients exhibiting signs of left ventricular failure.<sup>34-35</sup> Avery and co-workers<sup>15</sup> accepted the concept of poor tissue perfusion resulting in lactic acidemia as the primary cause of metabolic acidosis. There is good evidence<sup>30</sup> that metabolic acidosis tends to perpetuate pulmonary edema because of reduction in myocardial contractility. Moreover, it has been shown<sup>36</sup> that the myocardium is unable to respond to normal catecholamine support. Gerst and associates<sup>37</sup> demonstrated that the heart is unusually susceptible to ventricular fibrillation in the presence of metabolic acidosis.

*Respiratory Alkalosis*—There is ample experimental evidence to support the theory that pulmonary congestion stimulates respiration

by way of the Hering-Breuer reflex, and thus causes rapid shallow breathing.<sup>38</sup> Friedberg<sup>39</sup> mentioned that the concentration and tension of carbon dioxide in the blood is usually reduced and that this reduction is a secondary effect of the hyperventilation associated with dyspnea. To understand the manner in which pulmonary congestion induces the rapid shallow respiration, it should be recalled that the distensibility of the lungs is essential to their expansion during inspiration, and their elasticity is essential to their retraction during expiration, and that the lung, like erectile tissue, becomes rigid and inelastic when congested with blood. Because of the rigidity of the lungs, the normal increase in alveolar tension during inspiration causes relatively less expansion of the alveoli; for the same reason there is relatively less retraction during expiration than normally. Thus the end point of pulmonary inflation and deflation are brought closer together, with a consequent shallow respiration. More recently, Mills, *et al.*<sup>40</sup> demonstrated that vagal stimulation of intrapulmonary irritant receptors causes hyperventilation. Although there was no explanation for possible mechanism in the production of respiratory alkalosis, Avery and associates<sup>15</sup> found eight instances of respiratory alkalosis in 101 patients with pulmonary edema.

### Therapy of Acute Pulmonary Edema

Tradition on one hand and erroneous concepts on the other have many times prevented a rational approach to therapy. The traditional management of pulmonary edema includes: digitalis, diuretics, sedation, oxygen inhalation, aminophylline, phlebotomy, rotating tourniquets, fluid restriction, and DC countershock, if supraventricular or ventricular tachyarrhythmias are also present. In rare instances, signs and symptoms of acute pulmonary edema may be increased by a pleural effusion or caused by pericardial fluid, so that thoracentesis or pericardiocentesis should be performed.<sup>41</sup> If these measures fail and pulmonary edema is complicated by renal failure, peritoneal dialysis is recommended. Cardiac pacing may be tried if a critically slow heart

rate is also present. Mental obtundation in pulmonary edema (which so often is accompanied by restlessness and agitation) is a clue to carbon dioxide retention.<sup>16</sup> Arterial puncture should be performed and the blood analyzed for carbon dioxide tension ( $\text{PCO}_2$ ), oxygen tension ( $\text{PO}_2$ ), oxygen saturation, and hydrogen ion concentration (pH). Furthermore, venous blood should be analyzed for electrolytes and carbon dioxide combining power.

**Respiratory Acidosis**—The first consideration for correction of respiratory acidosis complicating pulmonary edema is the establishment of a patent and adequate airway. An oral airway should be inserted promptly and excessive secretions removed *via* nasotracheal suction. Adequate ventilation in patients with hypercapnia will require either a properly fitting mask or an endotracheal tube connected to either a volume-cycled or pressure-cycled respirator. Since higher pressures are often required to ventilate these patients due to decreased lung compliance,<sup>23</sup> intubation may be necessary. Both arterial blood gases and ventilation (frequency, tidal volume, minute volume) should be monitored during the acute phase.

The therapeutic efficacy of morphine in the treatment of patients with pulmonary edema has been documented by many clinical reports<sup>42-44</sup> and confirmed by experimental studies.<sup>45-46</sup> The mechanism by which morphine alleviates pulmonary edema, however, is poorly understood. Recent study<sup>47</sup> indicates that the beneficial effect of morphine in pulmonary edema may be principally attributed to the effect of the drug on the capacitance vessels of the peripheral circulation. The capacity of the peripheral vascular bed is increased, systemic venous return is reduced, and improvement results from a "pharmacologic phlebotomy." Morphine also effectively depresses the respiratory center and accordingly decreases the respiratory drive. Furthermore, it diminishes the psychic overstimulation accompanying fearful attacks. For these reasons, the anxiety, excitement, and apprehension of the patient is relieved. How-



ever, because of the depression of the respiratory drive, alveolar hypoventilation is inevitable with resultant carbon dioxide retention. Therefore, morphine should be given cautiously and in small dosage, pending the result of the arterial blood gases. If the patient is intubated and is on assisted ventilation, morphine administration can be given in the usual manner. Occasionally it may be impossible to ventilate adequately a patient with strong spontaneous breathing no matter what instrument is used. Although machine over-ride is often possible, a pattern of breathing that is rapid and shallow or grossly irregular may be forceful enough not to submit to the drive of a preset ventilator. In addition, the patient may "fight the machine," consciously or otherwise, because he is hypoxic, is fearful or apprehensive, or is emotionally unable to cooperate. In this instance, spontaneous breathing could be stopped by morphine administration.<sup>48</sup> There are no hard-and-fast rules for its administration, but a good basic program is 5 milligrams intravenously, repeated every ten minutes until desired effect is achieved—to a maximum of 20 milligrams for the series. In most patients, if morphine is to be effective it will be before this amount of the drug has been used.

The presence of obstructing, frothy, viscid fluid in the bronchial tree provides the basis for the use of surface active agents,<sup>49-50</sup> e.g., alcohol, which reduce the foaming. Alcohol acts by diminishing the surface tension, thereby affecting the stability of the thin film of edema fluid over air with resultant reduction in the obstructing effect of the foam, and facilitates more effective distribution of inspired oxygen. Ethyl alcohol in concentration of 25 to 50 per cent is administered by intermittent positive pressure breathing (IPPB). Oxygen and bronchodilator agents administered by IPPB, perhaps with the addition of an anti-foaming agent by nebulized mist, provide safe and immediate relief from both anoxia and the increased work of breathing. The hypoxia which develops in acute pulmonary edema with respiratory acidosis may be extremely severe. While reduction of  $PCO_2$  can be brought about slowly, it is im-

perative that the hypoxia be alleviated immediately through administration of oxygen. When the cause of hypoxia is purely reduction in alveolar ventilation, provision of an adequate alveolar ventilation alone will raise the arterial oxygen tension to a normal level. In the past, many physicians have been wary of administering oxygen to patients with ventilatory failure.<sup>22</sup> This was due to the belief that oxygen administration would abolish the hypoxic drive to breathing, and as a result cause a further fall in alveolar ventilation and aggravation of hypercapnia. However, the hazards of administration of oxygen to patients unable to maintain adequate alveolar ventilation have been over-emphasized. A slight rise in arterial  $PCO_2$  under adequate oxygenation is not associated with significant deleterious effects, and is in no way comparable to the potential danger of hypoxia.

Let us review briefly the physiologic effect of intermittent positive breathing (IPPB). On the heart, the IPPB reduces the venous return to the right heart based on the reversal of normal physiologic events. The great vessels that traverse the thoracic cavity and carry blood back to the heart are subject to changes in diameter with changing intrathoracic pressures, so that on forced expiration, as the chest wall compresses the lungs, the intrathoracic pressure rises, the vena cavae and azygous systems are compressed, and venous return to the right heart is diminished. During inspiration, the intrathoracic pressure is normally negative and blood return to the right heart is enhanced. IPPB reverses this normal relationship. During inspiration, intrathoracic pressure is elevated because air is being forced under pressure into the lungs, the large veins are compressed, and venous return may be completely occluded. In this situation, venous return must occur predominantly during expiration. Intermittent positive pressure breathing at a pressure up to 40 cm. of  $H_2O$  has been shown to retard blood return to the heart and found to be more effective than phlebotomy or rotating tourniquets.<sup>48</sup> Since hypoxemia and acidemia produce pulmonary vaso-constriction, administration of IPPB corrects these abnormalities by



uniform distribution of the inspired air. Emanuel and co-workers<sup>51</sup> have attempted to clarify the effect of IPPB on pulmonary circulation by measuring the ventilation-perfusion ratios before and after IPPB. They demonstrated that there was an increase in arterial oxygen tension after increasing the ventilation to poorly but well-perfused areas. Also, IPPB reduced the work of breathing by transferring the respiratory work load to the instrument.

*Metabolic Acidosis*—To correct this metabolic problem, sodium bicarbonate should be administered intravenously. Upon receiving the arterial blood gases, one ampule of sodium bicarbonate (44.6 mEq. of sodium bicarbonate in 50 cc. of water) is given for every 4 mEq. of negative base excess, e.g., a base excess of minus 12 would require three ampules. Arterial blood should be obtained and analyzed every 30 minutes during the acute phase, and additional bicarbonate should be administered until the base deficit is corrected. As many as ten ampules of sodium bicarbonate have been given<sup>15</sup> without aggravation of pulmonary edema; indeed, a brisk diuresis usually follows as the metabolic acidosis is corrected. Caress and associates<sup>30</sup> have shown that following administration of sodium bicarbonate in dogs with metabolic acidosis, there is a dramatic increase in  $dP/dt$  and left ventricular pressure with little change in peripheral resistance. It was felt that the sodium bicarbonate had some positive inotropic effect on the heart.

*Respiratory Alkalosis*—This biochemical disorder is probably induced by hyperventilation as a result of pulmonary congestion. Since

most of the patients are apprehensive and have a tendency to hyperventilate, the role of sedation in this situation is of paramount importance. Morphine sulfate must be given in the usual dose. If carpopedal spasm and clinical evidence of tetany are present, intravenous calcium gluconate, 10 per cent solution, should be administered. Since the  $PCO_2$  level is decreased, and one of the objects is to raise the  $PCO_2$  level, this could be accomplished by having the patient rebreathe into a paper bag.<sup>52</sup>

### Summary

Acid-base imbalance is a relatively common biochemical disorder accompanying pulmonary edema. Combined metabolic and respiratory acidosis are the most common abnormalities. Mortality is increased if complicated by these disorders, and survival appears to depend at least partly upon rapid correction of the acid-base derangement. The metabolic acidosis, probably the result of lactic acid accumulation as a consequence of poor tissue perfusion, should be treated promptly and vigorously by sodium bicarbonate intravenously. Respiratory acidosis secondary to alveolar hypoventilation with resultant hypercapnia and hypoxia should be treated by mechanical ventilation (Volume-limited or Pressure-limited respirators), with or without intubation. Arterial blood gas analysis should be a part of the routine evaluation of every patient presenting the clinical picture of pulmonary edema. Morphine should possibly be withheld or given in small doses until the  $PCO_2$  value is known or until ventilation and a clear airway are established.

A bibliographic listing of 52 citations is available from the author upon request.

Bergen Pines County Hospital

**PATRONIZE OUR ADVERTISERS**

# Upjohn's low-priced penicillin VK



## Uticillin<sup>®</sup> VK

(potassium phenoxyethyl penicillin, U.S.P., Upjohn)

Available in 250 and 500 mg tablets;  
250 mg/5 ml and 125 mg/5 ml flavored granules  
for oral suspension

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2144-6

*In a study of 100 mentally retarded residents at Woodbridge State School, 33 per cent showed a sella turcica of less than 80 square millimeters.*

# The Sella Turcica in the Mentally Retarded\*

**Manuel M. Villaverde, M.D. and  
Jacyntho Da Silva, M.D./Woodbridge**

Most retarded persons have the sella turcica within adequate limits. But it is of some clinical interest to know exactly what is found in the general population of the mentally retarded. This is the purpose of the present summary of findings in 100 residents in Woodbridge (New Jersey) State School.

A few retarded patients will show an abnormal sella reflecting either the primary cause or a secondary consequence of retardation. *A priori*, there are abnormalities of the sella among the mentally retarded in cases of pituitary tumors or hypoplasia, hydrocephaly, chondro-osteodystrophy (Hurler type), craniosynostosis, cretinism; and it is frequently small in microcephaly, osteo-petrosis, Arnold-Chiari malformation, lacunar skull, platybasia (basilar impression), and the cases of endocranial hypertension.

The group of our 100 mentally retarded patients was randomly selected for this study. The basic diagnosis and the number of cases in each category resulted as follows:

M.R. due to unknown cause	47 cases
M.R. with known cerebral defect or damage	28 cases
M.R. with mongolism	13 cases
M.R. with hydrocephalus	6 cases
M.R. with tuberous sclerosis	3 cases
M.R. with microcephaly	3 cases
M.R. with phenylketonuria	1 case

(Note: One case counts double because it is recorded into two different categories: mongolism and hydrocephaly.)

Our attention was focused on the shape of the sella, its diameters (anteroposterior, depth, and in some instances width), the sel-

lar-cranial index, area in lateral projections, and volume (only in ten instances of small sellae). The sella may be round, oval, flat (also called J-sella), triangular, and even irregular. It was also considered the so-called "excavation" (described by Timme, in 1921, as prevalent among the mongoloids), consisting of a depression formed beneath the anterior clinoids. The commonly used diameters are the anteroposterior and the vertical or depth. In few cases of supposedly small sellae, the transverse diameter (width), from one side to the other of the "waist" of the dorsum of the sella, in anteroposterior projections, was measured.

For the evaluation of the sellar-cranial index, the anteroposterior diameter of the skull was also measured. Then, the index was evaluated according to the formula:

$$S-C \text{ Index} = \frac{\text{AP diameter of the sella (in cm)}}{\text{AP diameter of the skull (in cm)}} \times 100.$$

By using a square millimeter graphic chart we determined directly the area of the sella from lateral projections. The sella was copied on a transparent film and then compared with our graphic chart, thus counting the number of square millimeters in each case.

After twelve years of age, we must assume that the sella turcica has achieved its full development (Gordon and Bell,<sup>6</sup> Royster and Rodman,<sup>14</sup> Heublein<sup>7</sup>). But there is also the opinion expressed by Davenport and Renfro<sup>1</sup>

\* From the Woodbridge State School Hospital, Woodbridge, New Jersey, where Dr. Villaverde is Staff Physician and Dr. DaSilva is Medical Director. Abraham Collis, M.D., Consulting Radiologist and Jeannette Murray, Radiology Technican are coauthors.



that the area of the sagittal section of the sella varies with age between ten and eighteen—usually increasing but also decreasing. Because almost all of our patients are over 10 to 12 years of age, we considered only one set of measurements for all of them.

Values accepted for the different dimensions of the sella vary considerably according to numerous researchers. The anteroposterior diameter, in millimeters, ranges from 5 to 20. The most frequent figures found are 8 and 9 to 15. Depth ranges from 3 to 16 but the most frequent figures are 6 to 10 millimeters. The width (or breadth) of the sella turcica shows greater variations, from 12 to 22. A reasonable mean figure for width in millimeters could be accepted as 14. The sellar-cranial index ranges from 5 to 7.

The volume of the sella turcica, in cubic millimeters, has been differently evaluated by radiologists, ranging from a minimum of 400 to a maximum of 2420. The most frequent figures given for the smallest sizes are about 500-600; for the largest size, about 1700; and for the average size, between 800 and 900 cubic millimeters. Volume of the smaller sellae, in all instances, fell below the accepted minimum of 560. In other words, the small sellae found in this study are actually small, of an average size of 450 cubic millimeters. In all instances the width of the sellae fell below the accepted standards.

Among our mentally retarded subjects, the most usual shape of the sella is the oval. The irregular type reveals a substantial number: 10 cases (21 per cent), and there are 6 examples (14 per cent) of the flat type. Very few of these sellae reveal an excavation. Excavation is most frequently found among those with an irregular sellae. The anteroposterior diameter was found normal in a large number of instances (83 per cent). The sellar-cranial index was normal in 64 per cent, and large only in 6 per cent. The small index was accompanied by small sella in 11 instances; the average indices came with small area in 4 cases and with large area in 2 other instances. The 3 large indices were not accompanied

by large areas. The sellar-index reveals an adequate correlation to the sellar area in 79 per cent of instances.

In this series, 28 subjects had a diagnosis of some sort of cerebral damage or defect, including cerebral infection, encephalitis, birth injury, anoxemia at birth, cerebral palsy, and even familial or genetic influences among others. The shape of the sella in this group is preferently round (36 per cent). Three of the seven irregular sellae showed excavation. The anteroposterior diameter was of average size in all but three instances, that is in 89 per cent. The S-C index was average in most cases (68 per cent), but there were many instances (32 per cent) of a small index and none of a large one.

The thirteen mongoloids show some interesting findings. The shape of the sella is either round (46.5 per cent) or flat (38.5 per cent) in the great majority of the cases. Only two of the flat sellae presented excavation under the anterior clinoids. Two large sellae were found among mongoloid patients, which sellae were oval or flat and both had large anteroposterior diameter. There were no small anteroposterior diameters in this group and only 23 per cent of small S-C indexes. One small sella under 40 square millimeters also presented a small S-C index. The correlation area-index is better for the large sellae; the correlation index-area is only fair, in general.

In the three cases of microcephaly, the sella was small in two instances, in one of them with small S-C index. The latter was round, and the other one was irregular, with excavation present. There was one flat sella on the upper limits for normal area, which presented a normal S-C index, but a large anteroposterior diameter. In this case, in spite of the diagnosis maintained by several doctors, the anteroposterior diameter of the skull was not small.

Three cases with tuberous sclerosis presented normal anteroposterior diameters. In one of the cases the S-C index was small, as well as the triangular sellae; a second case also

showed small sella. Only one case of phenylketonuria was recorded with a flat sella (excavation present) and a large anteroposterior diameter and large S-C index, but the area was normal.

The great majority of patients (78 per cent) reveals the anteroposterior diameter of average size (between 8 and 14 millimeters). In spite of the tendency to small sellae, large diameters were found in 12 per cent of the cases and small diameters in 10 per cent.

The correlation area index results are informative in about 75 per cent of the cases when both area and index are within normal limits. Small indices give also an acceptable correlation (72.5 per cent); but the large ones failed to give good information (78 per cent with no correlation). In the case of sellae of small area, the correlation was slightly lower (63.5 per cent), and with large sellae we found a good correlation only in 40 per cent of the instances; but the number of cases was low.

The so-called "excavation" was not of any significance in this series. It was found only 20 times among the 100 patients; a figure far from that quoted by Gordon and Bell,<sup>6</sup> even if considering exclusively the "uncovered excavation," which was found in 33 per cent of their cases. No more than three of our thirteen mongoloids (23 per cent) did show the "excavation."

Spilzer, Rabinowitch and Wybac<sup>16</sup> did not find any changes about the sella in their radiographic study of 29 cases of mongolism. Fischer and DiChiro<sup>4</sup> found five small sellae (8 per cent) among their mongoloids.

In a study of mentally retarded patients, Gordon and Bell<sup>6</sup> found that the shape of the sella is almost equally round or oval (43 per cent and 42 per cent, respectively), and only a small per cent (15) corresponds to flat sellae. They conclude that no one shape predominated in any individual disease. In patients with mongolism, they found the "excavation" present in 81 per cent of the cases; but it was also present in 77 per cent of normal children. The size of the sella did not

show any important variation corresponding to any particular disease. In three cases of infantilism, with small heads, the sella was small in only one instance; two, out of three, hydrocephalic patients showed large sellae; but in their series, mongolism idiocy showed some of the largest sellae (with no regularity enough to make it of diagnostic importance). They conclude that the type of disease is not completed with the shape of the sella, and that there is no formation characteristic of any individual disease.

Generally speaking, the main abnormality of the sella is when it enlarges due to tumoral lesions of the hypophysis. Small sellae are not a frequent finding in the corresponding x-ray reports in the medical literature. Fischer and DiChiro<sup>4</sup> studied a group of 1000 individuals, and stated that only 3 per cent of the sellae were of small size. When they found six small sellae in a group of 39 cases of myotonic dystrophy (about 15 per cent), they concluded that in this disease there is a significant predominance of small sellae.

In our study of 100 mentally retarded patients, we found that any type of sella can be present—most frequently the round type, but also the flat and the irregular. The anteroposterior diameter is mostly of average size, even when the sella is small. A large proportion of cases show small sellae; and most of the sellae of normal size are in the smaller half of the group, that is, are of less than 80 square millimeters. When we consider the average size for our cases, it is smaller than for the general population. We found 33 per cent of small sellae in our series, which is double the figures considered significant in other conditions.

## Summary

In a randomized series of 100 mentally retarded residents, at Woodbridge State School, the sella was found to be smaller in size than for any average population—33 per cent of the cases showed a sella of less than 80 square millimeters. The average area for these patients is 61 square millimeters.

## Bibliography

1. Davenport, C. B. and Renfroe, O.: *Am. J. Roent.*, 44:665 (1940)
2. DiChiro, G. and Nelson, K. B.: *Am. J. Roent.* 87:989 (1962)
3. Dutou, L. and Colon, J.: *Ann. Radiol.*, 7:581 (1964)
4. Fisher, R. L. and DiChiro, G.: *Am. J. Roent.*, 91:996 (1964)
5. Gibson, W. S.: *Surg. Gynec. & Obst.*, 15:199 (1912)
6. Gordon, M. B. and Bell, A. L. L.: *New York State J. Med.*, 22:54 (1922)
7. Heublein, G. W.: *Am. J. Roent.*, 56:299 (1964)
8. Howe, H. S.: *Neurol. Bull.*, 2:233 (1919)
9. Martinez-Farinas, L. O.: *Radiol.*, 88:264 (1967)
10. New, P. F. J.: *Radiol. Clin. N. Amer.*, 4:75 (1966)
11. Oon, C. L.: *Brit. J. Radiol.*, 36:294 (1963)
12. Raguz, R., Haro, F. and Villaverde, M.: *Am. Med. Int.*, 1:261 (1932)
13. Riach, I. C. F.: *Med. Digest*, 14:25 (1968)
14. Royster, L. T. and Rodman, N. I.: *Tr. Am. Pediat. Soc.*, 34:246 (1922)
15. Scheuermann, H.: *Ata. Radiol.*, 13:404 (1932)
16. Spilzer, R., Rabinowitch, J. Y. and Wybac, K. C.: *Canadian M.A.J.*, 84:567 (1961)
17. Voluter, G.: *Radiol. Clin.* (Vol. 28, supp.) (1959)

Woodbridge State School Hospital

## Coronary Vasodilator Efficacy\*

Long-acting coronary "vasodilators," widely prescribed in the management of angina pectoris, will require extensive study as a result of a National Academy of Sciences report questioning evidence on the drugs' effectiveness. The NAS/NRC panel, after evaluating all available evidence about the drugs, concluded: isosorbide dinitrate tablets, when administered by the *sublingual* route, are "probably" effective for the treatment of attacks of angina pectoris and for prophylaxis in situations likely to provoke such attacks. The same drug (isosorbide dinitrate tablets) is only "possibly" effective for the same indications when administered *orally* (swallowed).

Extended action or conventional oral dosage forms of pentaerythritol tetranitrate, trolnitrate phosphate, and mannitol hexanitrate—alone or in combination with other drugs—are "possibly" effective for the treatment or prevention of anginal attacks. Sustained action nitroglycerin tablets are "possibly" effective for the treatment or prevention of angina attacks.

*Probably effective* signifies that for a particu-

*lar indication* the available evidence indicates that a drug probably accomplishes its proposed effect, but that additional evidence is required before the drug can be deemed "effective" beyond reasonable doubt.

*Possibly effective* signifies that little evidence of effectiveness for the given indication has been obtained. The possibility that adequate supporting evidence might be developed should not be ruled out, however.

FDA recognizes that these drugs are widely regarded by physicians as safe and useful in the management of angina pectoris in some patients. It also recognizes the difficulty of designing and executing controlled clinical studies for anti-anginal drugs. For these reasons, the Agency will allow manufacturers sufficient time to complete the required studies and the drugs will continue to be marketed during that time. FDA will keep physicians informed as the studies develop.

On the basis of the NAS/NRC panel's conclusion, physicians may wish to re-evaluate the role of long-acting coronary vasodilators for their patient.

\* From the February 1972 FDA Drug Bulletin.



*This modest paper reports good results following hernia repair where postsurgical disability is minimized.*

# Hernia Repair Without Disability

---

**Richard A. Raffman, M.D./Madison**

*Hernia Repair Without Disability*, a book by Irving Lichtenstein, (C. V. Mosby, St. Louis, 1970) was reviewed rather unfavorably in *The Journal of The Medical Society of New Jersey* (October, 1971). To quote the reviewer, "the author's contribution to hernia repair, the Lichtenstein repair, is essentially the same as the classical Halsted repair."

This misses the point of the presentation, which is that Lichtenstein has cracked the medico-legal barrier which has meant, in New Jersey at least, that a hernia patient shall be kept in the hospital for five to seven days and that he shall be disabled for six weeks thereafter. Lichtenstein says, in effect, "throw away your truss and walk." His patients walk from the operating room, exercise the same day and return to work the day after if they have the desire. His recurrence rate is not higher than other series of cases and his morbidity seems to be less. The secret of his success seems to be the use of local anesthesia, patient cooperation so that suture lines may be tested by extreme stress at each stage of the operation, and the use of permanent, non-absorbable, non-reactive suture material.

There is probably no surgeon in New Jersey who has not, at one time or another, tried some or all of Lichtenstein's methods. Yet I know of no New Jersey report of a significant series of cases operated on using these principles, nor of any systematic attempt to solve the problem of prolonged hospitalization and disability after hernia repair. The medico-legal barrier which dictates five to seven days

in the hospital and then six weeks of disability can be put into perspective when one realizes that Blue Cross alone paid out almost \$5,000,000 in *per diem* charges for hernia repair in patients under 65 in New Jersey last year. This represents 8,879 hernias, 55,635 days at \$86 per diem, an average of 6.3 days per repair. Presumably this also includes a significant number of children and infants who are usually discharged on the first or second post-operative day. One can see that a modest 25 to 33 per cent reduction in this hospitalization could more than pay for the entire kidney transplant program in New Jersey.

Since September 1964, I have systematically done all of my hernia operations under local anesthesia except on children who were excluded for obvious emotional reasons, if for no other. My entire series, going back to 1962, comprises 136 patients on whom I repaired 194 groin hernias. Twenty-nine patients were children under the age of 12 and are hereafter excluded. This leaves 107 patients on whom 146 hernias were done, 116 under local, 28 under general and 2 under spinal. My technic has developed by evolution, although I find that it closely approximates that of Lichtenstein. A careful explanation of the procedure and even some practice grunting and coughing are essential. I obtain permission for the operation to be done under local or general in case there should be an anesthetic failure. (There has been none.) Appropriate amounts of meperidine, promethazine, and atropine are given at least one hour before surgery, preferably two. Skin preparation in the operating room must be done carefully and always with an aqueous solution such as povidone or

benzalkonium. Drapes are applied, being careful to keep towel clips out of the skin. A field block of 10 to 20 cubic centimeters of 2 per cent mepivacaine is injected just anterior and medial to the anterior superior iliac spine. I supplement this with an additional one half per cent mepivacaine in the skin and in the area of the pubic tubercle. Additional anesthesia is given locally just under the sheath of the external oblique and when the patient feels any sharp pain. Usually a small amount must be injected into the area surrounding the neck of an indirect hernia sac as well. On a bilateral operation, I never use over 30 cubic centimeters of 2 per cent mepivacaine and 100 cubic centimeters of one-half per cent.

A nurse-anesthetist or anesthesiologist monitors the pulse and blood pressure throughout the procedure. A drip of 5 per cent glucose and water is usually used but vasopressors have never been necessary. Transient hypotension has been treated by lowering the head of the table and giving oxygen.

The operative procedure itself must be done slowly and gently, as the patient will have some deep sensation. Dissection must always be with a knife or the scissors. Finger dissection, the tearing of tissue and sudden maneuvers must be avoided as they are perceived as pain. Care must be taken to ligate even small bleeders. In short, good, gentle surgical technique is necessary throughout. I now use 2-0 Tycron for the repair, although I have used Tevdek, Mersilene, and 2-0 monofilament stainless steel wire. I usually do a simple Bassini repair, being careful to approximate fascia to fascia without the interposition of muscle. Relaxing incisions are used when necessary. Halsted or McVey repairs are used when indicated. I have used Teflon mesh only once.

As the repair progresses, the patient is asked to cough, to strain, to sit up slightly, and to raise the ipsilateral leg. This tests the strength of the tissues and the tightness of the repair. Surgical judgment dictates each step in the dynamic reconstruction of the inguinal region. I do not hesitate to remove a row of sutures and start all over again if I am not

convinced of the integrity of the repair.

Finally, the subcutaneous tissue is closed with 3-0 plain and the skin with 3-0 nylon. The entire operation usually takes 45 minutes for one side and about an hour and a quarter for both sides.

The patient is usually sent directly back to his room with an ice pack on the groin for 24 hours. Bathroom privileges are allowed the same afternoon and walking in the hall is mandatory the next day. Meperidine is sometimes necessary for pain the first day, but thereafter, propoxyphene or pentazocine suffice. A mild tranquilizer such as meproamate, four times a day, may be given for two or three days.

Post-operative catheterization, enemas, or laxatives are rarely necessary and the patient goes home not later than the third post-operative day, to return to work whenever he wishes. For those in sedentary occupations, this is usually the following week; for teachers, salesmen, and so on in two weeks; and for laborers about four weeks. Students have returned to classes two days after the operation, business executives are back at their desks within a week and truck drivers can be on the road in two weeks. Since reflexes may be somewhat retarded, the patient must be cautioned about driving a car.

### Patient Selection

If the patient needed the operation and could lie flat on the table for an hour or so, and if he could cooperate with the surgeon, he was not refused the operation. Eight patients have had high blood pressure and arteriosclerotic heart disease, six had cirrhosis, six chronic bronchitis, two asthma, two emphysema, five gout, and four diabetes. Age was no barrier—the patients ranging from 14 to 88, with ten patients over 65.

### Complications

The only death in my entire series was a 91-year old man operated on for acute strangulation under general anesthesia early in the

series. On the sixth post-operative day, he suffered a massive cerebrovascular accident and died. There were two serious complications, one after general anesthesia in a patient who suffered endotoxin shock after resection of a large segment of gangrenous bowel. In the series under local, one patient developed thrombophlebitis. Minor complications under local anesthesia include two wound hematomata, one severe scrotal edema, and two temperature elevations of one day.

In my experience, under general anesthesia there were two patients with severe scrotal edema, four with temperature elevations, and one with a wound infection.

## Results

Of the patients done under local, 37 have been followed for two or more years. There is no proved recurrence, although one patient who now lives out of state and could not return for examination thinks he has a cough impulse. One patient, done eight years ago

under general, developed a wound infection requiring removal of sutures and secondary repair which was successfully done under local.

So far as patient acceptance is concerned, of 21 who ventured an opinion, 18 said they would undergo another operation under local anesthesia if necessary, three said they would not. Admittedly, these favorable opinions must be taken with a grain of salt.

## Summary

Large series of hernia repairs under local with early hospital discharge and return to work have been reported in this country and in Canada. This report is of a smaller series of cases reported by a "country surgeon" working in a non-teaching community hospital in New Jersey. The results are equally good. Patient acceptance has been high and there are significant factors of secondary gain to the patient and to society which merit serious consideration by the surgical fraternity.

28 Walnut Street

## Many New Jersey Medical Alumni To Remain Here

Approximately half of the 1972 graduating class at the College of Medicine and Dentistry of New Jersey—New Jersey Medical School—will remain and serve internships in New Jersey hospitals, and in particular Martland Hospital, the school's primary teaching hospital.

Of the 87 seniors in the graduating class, 69 applied for internships through the National Intern Matching Program. Thirty-three of these applicants will remain in New Jersey. In addition to New Jersey Medical School graduates, Martland has also accepted for internships 10 graduates of other American medical schools and 5 graduates of foreign medical schools. Speaking of this, Dr. Stanley S. Ber-

gen, Jr., College President, noted, "One of the most significant statistic of this year's internships is not only the number of our own graduates who chose to remain in New Jersey, and in particular at Martland Hospital, but the number of graduates of other medical schools who are coming to New Jersey. Of the ten graduates of other American medical schools who will intern at Martland, most are New Jersey residents who are returning to the state. When the new medical-dental complex, now under construction, is completed, the college will graduate 160 to 200 physicians a year. When Rutgers Medical School completes its transition to a four-year degree-granting institution, 160 more will be graduated.





Overcrowding, unemployment, discrimination and hunger contribute to mental illness. They also serve as barriers between the poor and proper diagnosis and effective treatment of mental illness.

The National Association for Mental Health is committed to tackling the problems of the disadvantaged, by helping them secure the benefits of advances in the prevention, diagnosis and treatment of health problems.

Your Mental Health Association is working to ensure that services for the mentally ill are provided in areas where they are needed the most.



**JOIN AND SUPPORT YOUR  
MENTAL HEALTH ASSOCIATION**

*Citizens Who DO Make A Difference*

# He won't resist feeling better with **Mylanta<sup>®</sup>**

Because the taste is good.

- ☐ promptly relieves hyperacidity
- ☐ also relieves fullness and bloating
- ☐ non-constipating



LIQUID **MYLANTA<sup>®</sup>** TABLETS

aluminum and magnesium hydroxides with simethicone



STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts. Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen**<sup>®</sup>).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of menorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**<sup>®</sup>).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

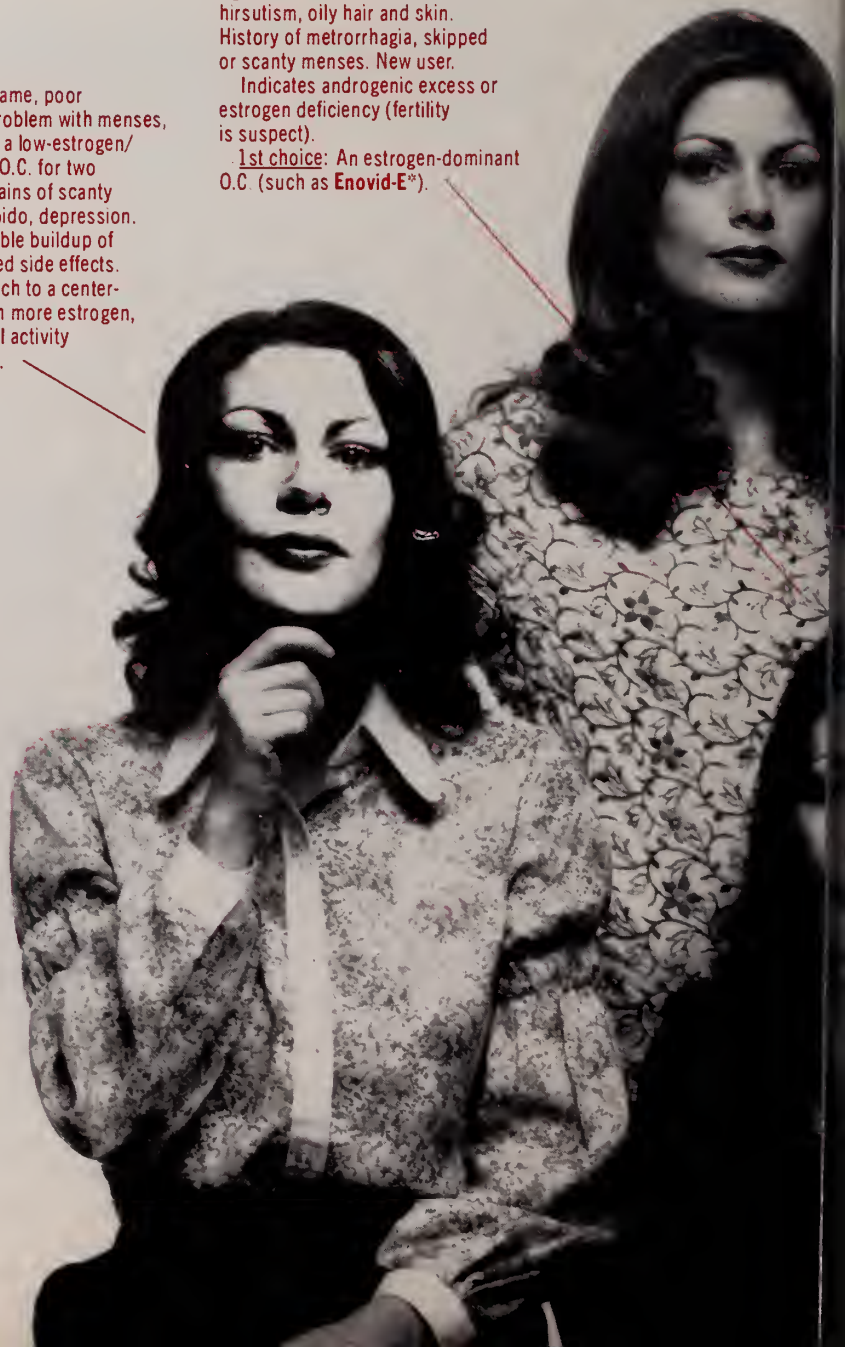
Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**<sup>®</sup>).

Age 21, short, mammary, with normal menses, some acne. Was put on premarin regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E**<sup>®</sup> or a sequential).





e 25, tall, slender, athletic,  
h flat chest. On a progestogen-  
minant 50-mcg.-estrogen O.C.  
s recurrent trichomoniasis  
d Monilia.  
Indicates estrogen deficiency and  
cess of progestogen in current O.C.  
**1st choice:** Switch to a com-  
bination pill with 100 mcg.  
estrogen and less progestational  
activity (such as **Enovid-E**® or  
**Ovulen**® or a sequential).

Age 23, "Miss America" figure,  
previously normal menses, healthy  
skin and hair. On a 50-mcg.-  
estrogen pill for four months.  
Complains of intracyclic bleeding.  
Indicates probable need for  
more estrogen.  
**1st choice:** Switch to a center-  
spectrum O.C. with more estrogen  
and moderate progestogen  
dominance (such as **Ovulen**®).

Age 21, college senior, average  
build. On highly progestogen-  
dominant/low-dose-estrogen O.C.  
for six months. Now complains of  
amenorrhea, between-cycle  
headaches, weight gain.  
Indicates probable progestogen  
excess.  
**1st choice:** Switch to a center-  
spectrum pill (such as **Ovulen**®).

Age 27, slightly overweight,  
multiparous. Nausea with all three  
pregnancies and with a sequential  
O.C. three years ago. Has pre-  
menstrual fluid retention and  
leg cramps.  
Indicates probable excess of  
estrogen.  
**1st choice:** A 50-mcg.-estrogen/  
progestogen-dominant pill  
(such as **Demulen**®).

**Ovulen**® a balanced  
center-spectrum O.C.  
for most

Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

**Demulen**® a moderately  
progestogen-dominant O.C.  
for many

Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.  
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

SEARLE

Products of SEARLE & CO.  
San Juan, Puerto Rico 00936

**Enovid-E**® a moderately  
estrogen-dominant O.C.  
for some

Each tablet contains norethynodrel 2.5 mg./mestranol 0.1 mg.

SEARLE

Product of Searle Laboratories Division  
G.D. SEARLE & CO.  
P.O. Box 5110, Chicago, Illinois 60680  
Where "The Pill" Began

or a brief summary  
prescribing information,  
please see next page.

a family of O.C. products to help you match  
the right pill to the right patient

# Ovulen®

Each white tablet contains  
ethynodiol diacetate 1 mg / mestranol 0.1 mg.

# Demulen®

Each white tablet contains  
ethynodiol diacetate 1 mg / ethinyl estradiol 50 mcg

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function; increased sulfobromophthalein retention and other tests; coagulation tests; increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values, metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners. Oral Contraception and Thrombo-Embolic Disease, *J. Coll. Gen. Pract.* 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P. Investigation of Deaths from Pulmonary Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, *Brit. Med. J.* 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R. Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, *Brit. Med. J.* 2:651-657 (June 14) 1969. 4. Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E. Thromboembolism and Oral Contraceptives. An Epidemiologic Case-Control Study, *Amer. J. Epidemiol.* 90:365-380 (Nov) 1969.

**SEARLE** Products of SEARLE & CO.  
San Juan, Puerto Rico 00936

## Enovid-E®

norethynodrel 2.5 mg / mestranol 0.1 mg

**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The Special Note, Contraindications, Warnings, Precautions and Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

## Enovid-E®

brand of norethynodrel with mestranol

**SEARLE** Product of Searle Laboratories Division  
G. D. SEARLE & CO.  
P.O. Box 5110, Chicago, Illinois 60680  
**Where "The Pill" Began**



*Even in an 80-year old, the bradycardia-tachycardia syndrome has been successfully managed.*

# Bradycardia-Tachycardia Syndrome\*

## Treatment with Transvenous Ventricular Pacing and Antiarrhythmic Drugs

**Martin B. Wartenberg, M.D. and  
William F. Haynes, Jr., M.D./Princeton**

The use of transvenous ventricular pacing in the management of heart block (or other arrhythmias associated with an abnormally slow ventricular rate) is well established. There are occasions when a patient may alternate between periods of A-V nodal bradycardia and supraventricular tachycardia (S.V.T.).<sup>1</sup> The dilemma facing the clinician is the inability safely and effectively to use digitalis and certain other antiarrhythmic drugs for fear of aggravating the bradycardia. This report describes the successful combination of a pacemaker and antiarrhythmic drugs in solving this problem, as detailed in a patient with the so-called "bradycardia-tachycardia syndrome." In addition, the current electrophysiological basis for this syndrome is discussed.

An 80-year old woman was admitted for the first time to Princeton Hospital in 1966. She had a history of angina on exertion, and EKG studies showed T changes suggestive of acute coronary insufficiency plus evidence of an old posterior wall myocardial infarction. She was admitted for a second time in 1968 because of fatigue and palpitations associated with dizziness. Clinical and EKG data revealed episodes of S.V.T. The patient was digitalized and subsequently improved. Shortly afterwards, however, signs of digitalis toxicity occurred, which made it necessary to stop the drug. The patient remained asymptomatic until January 1971, when she noted progressive shortness of breath and swollen feet. A left pleural effusion was noted. She improved with the aid of diuretics and bed rest. Chest x-rays subsequently cleared. Three weeks later, she was readmitted because of weakness and chest discomfort. On admission she appeared mildly dyspneic and slightly confused. Physical examination revealed a BP of 110/70, pulse 140 and regular, R-22, T-98. Head, eyes, ears, nose, and throat were normal. No jugular vein distention was noted. An apical pulse was not palpable. Auscultation revealed a regular tachycardia. No murmurs were de-

tected. The lungs were clear and well ventilated. Abdominal examination was unremarkable. Fair peripheral pulses were present, and no ankle edema was observed.

Admission laboratory values included the following: hemoglobin 15.7; hematocrit 48 per cent; white blood cell count 9,400; erythrocyte sedimentation rate 23 mm/hr. (Westergren); urinalysis was normal; sodium 124 mEq/liter; potassium 4.2; chloride 95; serum carbon dioxide level 27; serum creatine phosphokinase 39 units; serum lactic dehydrogenase 200 mU/ml; serum glutamic oxaloacetic acid transaminase (SGOT) 110 mU/ml. Chest x-ray was normal.

The patient was placed in the CCU and monitored. Quinidine, 200 milligrams, every six hours, was started on the day of admission as it soon became apparent that the patient's rhythm alternated between periods of S.V.T. (140 to 150 beats per minute) and sinus bradycardia (40 to 50 beats per minute). Onset of her bouts of S.V.T. were preceded by an atrial premature depolarization, falling within the relative A-V refractory period. (Figure 1). The episodes of S.V.T.

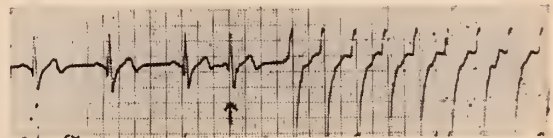


Figure 1—Shows initiation of an episode of S.V.T. Note premature atrial depolarization triggers episode of S.V.T.

were characterized by a shift in electrical axis and the appearance of a RBBB. (Figures 2 and 3). Despite increasing the quinidine to 200 milligrams every four hours, the S.V.T. could not be controlled. The patient became progressively more confused. Severe symptoms of congestive heart failure appeared, and a right pleural effusion was observed radiographically. Because of the inability to control the episodes of S.V.T. by the use of quinidine, and the fear of giving digitalis in view of her bradycardia, a temporary bipolar transvenous pacemaker catheter was inserted into the right ventricle on the eleventh hospital day. The pacemaker demand rate was fixed at 80 beats

\* From the Department of Medicine at The Princeton Hospital, Princeton. Dr. Wartenberg is a medical intern, and Dr. Haynes is attending in Internal Medicine at the hospital and Clinical Assistant Professor of Medicine at Rutgers Medical School, CMDNJ.



per minute. Subsequent episodes of S.V.T. were controlled with digoxin, quinidine, and propranolol.<sup>†</sup> Complete remission of bouts of S.V.T. was achieved, but three days after the initiation of propranolol symptoms and signs of congestive heart failure were

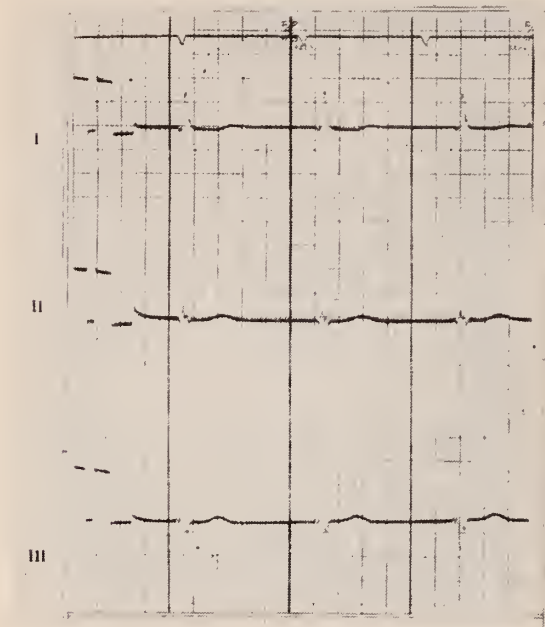


Figure 2—Previous to initiation of S.V.T., left axis deviation and no evidence of bundle branch block are noted.

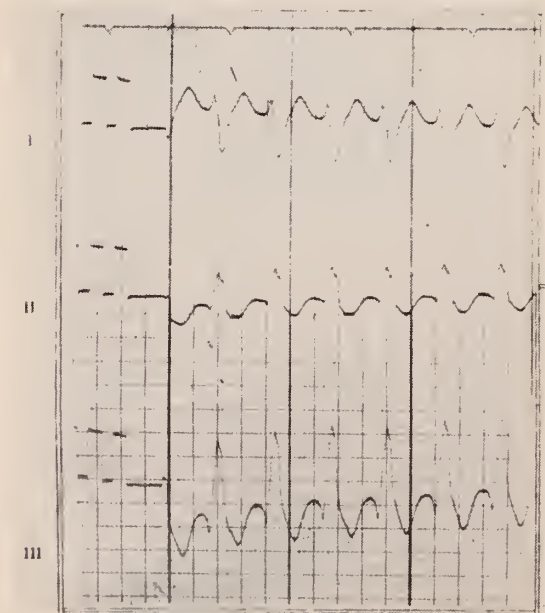


Figure 3—Episode of S.V.T. is characterized by shift in electrical axis to the right and appearance of right bundle branch block.

<sup>†</sup> Nonproprietary and trade names of drugs: Digoxin—Lanoxin; Quinidine—Quinora; Propranolol—Inderal

noted. Propranolol was, therefore, discontinued, and a diuretic was substituted resulting in sustained clinical improvement. On the sixteenth hospital day, a permanent demand pacemaker was inserted and the temporary pacemaker catheter was removed. The pacemaker was set to capture the ventricles at rates below 72 beats per minute. The patient was discharged improved on the twenty-second hospital day.

Some authors have used the term "sick sinus syndrome" when referring to patients exhibiting slow sinus node, atrial, or A-V junctional rhythms. These patients are susceptible to intermittent bouts of S.V. tachyarrhythmias. The name "bradycardia-tachycardia syndrome" has been given to this. The bradycardic phase has been thought due to electrophysiologic disturbances in the formation or conduction of the sinus impulse. S-A block has been shown to be at least part of the problem, but no definite explanation of its mechanism has been given.<sup>2</sup> When bradycardia becomes marked, leading to long periods of asystole, syncope may occur. Subsequent failure of atrial or A-V junctional "escape" pacemakers to emerge in the presence of the S-A block accounts for the asystole. The term "Sino-Atrial Syncope" has been used for this condition.<sup>3</sup>

During the phase of bradycardia, several factors could have a role in the development of S.V.T.: (1) Slow rates predispose to ectopic formation of impulses because prolonged diastolic depolarization gives a greater opportunity for latent ectopic pacemakers foci to discharge; (2) With slow rates a greater disparity in the rate of recovery of excitability between neighboring areas of myocardium occurs.<sup>4</sup> "Re-entry" is accepted as the mechanism of onset and perpetuation of recurrent bouts of S.V.T. The site of the re-entry has been demonstrated to lie within the A-V node.<sup>5</sup> A dual A-V conducting system is necessary to explain both a reciprocal rhythm and the re-entry phenomenon.

The case described shows a very interesting feature. During the periods of bradycardia, left axis deviation and no presence of bundle branch block were observed. (Figure 2). When S.V.T. occurred, change on the axis to right axis deviation and presence of a functional

RBBB were noted. (Figure 3). It has been demonstrated that there exists an inhomogeneity of conduction among nerve fibers located in the A-V node. Impulses travel faster and preferentially through fiber bundles located in the left side of the A-V node.<sup>6</sup> Thus, during a certain phase of normal electric repolarization of the heart, the left bundle will be fully repolarized, while the right bundle of the A-V node is still refractory and depolarized.<sup>7</sup> A premature atrial beat occurring at this time, finding the right bundle refractory and unable to transmit an impulse, will instead travel down the left bundle. This results in a functional *antegrade* block in the right bundle. By the time this impulse has been conducted through the left bundle and Purkinje fibers, the right bundle, previously refractory, has had time to repolarize. The same impulse now will travel in a *retrograde* fashion through the right bundle and re-entry will take place in the A-V node. The impulse reaching the A-V node will now re-enter the left bundle that at this moment is repolarized, leading to a perpetuation of re-entry and therefore of S.V.T. Retrograde activation of the atrium occurs but does not play an important role in what is happening at the A-V node or bundle of His, other than keeping the S-A node depolarized and preventing it from initiating an impulse. An ectopic atrial stimulus at a certain time in the re-entry cycle will terminate the reciprocal rhythm if it falls during a time just prior to re-entry at the A-V node. The use of electrical pacing in the management of the bradycardia-tachycardia syndrome is beneficial in three ways: (1) bradycardia can be controlled and a proper rate

of ventricular contraction can be achieved; (2) the use of antiarrhythmic drugs to prevent recurrence of episodes of S.V.T. can be given without fear of increasing the hazards of bradycardia; and (3) with ventricular pacing, blocking of the re-entrant impulse can be obtained, thus terminating a paroxysm of S.V.T.<sup>8</sup>

## Summary

The successful management in the community hospital setting of an 80-year old woman exhibiting the "bradycardia-tachycardia syndrome" is described. The combined use of a permanent demand cardiac pacemaker and antiarrhythmic drug therapy appears to be the treatment of choice. The current electrophysiological concepts involved in the etiology of this syndrome are discussed and illustrated by appropriate electrocardiograms in the above patient.

## Bibliography

1. Cheng T. O.: *Amer. J. Cardiol.*, 22:874 (1968)
2. Scherf, D.: *Amer. J. Cardiol.*, 23:769 (1969)
3. Easley, R. M. and Goldstein, S.: *Amer. J. Med.*, 50:166 (1971)
4. Zipes, D. P., Wallace, A. G., Sealy, W. C., and Floyd, W. L.: *Ann. Intern. Med.*, 70:885 (1969)
5. Goldreyer, B. N. and Bigger, J. T.: *Circulation*, 43:15 (1971)
6. Watanabe, Y. and Dreifus, L. S.: *Amer. Heart J.*, 76:114 (1968)
7. Schamroth, L. and Yoshonis, K. F.: *Amer. J. Cardiol.*, 24:224 (1969)
8. Zeft, H. J. and McGowan, R. L.: *Circulation*, 40:919 (1969)

Medical Arts Building

## Alternatives to Malpractice Litigation

The U.S. Public Health Service is now making available a 28-page brochure on "Alternatives and Quality Control System in the Field of Medical Malpractice." This explains the legal background, presents the case for and against the much talked-over "no fault sys-

tem," reviews the possibility of an arbitration tribunal and, in general, gives a three dimensional perspective of the problem. A copy of this brochure is available for \$1 from the Center for the Study of Democratic Institutions, Box 4546, Santa Barbara, California.

# When you prescribed Orinase<sup>®</sup> (tolbutamide, Upjohn) 14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

**Contraindications:** Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

**Pregnancy Warning:** The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated fetocidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

**Precautions:** Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restriction; not to develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the treatment period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limitations of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physician.



# Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know that if these measures fail the addition

of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

## Orinase® 0.5 g. tablets (tolbutamide, Upjohn)

ian daily, and during the first month report at least once weekly or physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

**Adverse Reactions:** Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenylamidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without pro-

ducing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity; crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

**Supplied:** 0.5 g. Tablets—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

**For additional product information, see your Upjohn representative or consult the package insert.**

The Upjohn Company, Kalamazoo, Michigan 49001

**Upjohn**

© 1971 The Upjohn Company JA71-1495 MED B-5-S LAO-6

**"Prescribe With Confidence"**

**K A T E S   B R O S .**

**SCIENTIFIC SHOE FITTING**

A Shoe and Last for Every Foot

*Barefoot & Freedom*

---

SOLD ON Rx ONLY  
CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN  
OUTFLAIR SHOES FOR CLUB FEET

---

**400 MAIN STREET**

**HACKENSACK, N. J.**

**201-487-1779**

Dennis Brown Splints — In all sizes — Carried in stock  
**CUSTOM SHOE SHOP ON PREMISES**

# Suicide

David Lester, Ph.D./Pomona\*

Every year in the United States some 20,000 people kill themselves. In addition, somewhere between 150,000 and 200,000 will make an unsuccessful attempt to kill themselves. Because of the accumulation of suicidal acts from past years, there may be close to two million people in the United States who have a history of at least one suicide attempt.<sup>1</sup>

Recently, there has been some protest against the current emphasis on suicide and suicide prevention. Critics note that other causes of death, such as cancer, take a far higher toll of life. However, when we realize that two million Americans have attempted suicide out of a population of two hundred million and that many millions more have considered suicide, it is clear that the problem of suicide is one of vast proportions.

New Jersey does not have a particularly high rate of completed suicide. In 1960, New Jersey ranked 44th of the 50 states with a rate of 8.3 per 100,000 per year. Of the 57 major metropolitan areas (population greater than 500,000) Jersey City ranked 36th, Paterson-Clifton-Passaic ranked 51st, and Newark ranked 56th.

However, suicidal deaths are not recorded accurately.<sup>2</sup> Many suicidal deaths are certified accidental or natural and when the certification of death is made more accurate, the suicide rate is found to be higher than hitherto reported. In Los Angeles today, for example, the suicide prevention center works closely with the coroner's office to ensure accurate certification of equivocal deaths. Thus, the number of suicidal deaths in Los Angeles is known quite accurately.

## Completed Suicide in New Jersey†

In New Jersey in 1970 there were 507 certified suicidal deaths. Breakdown of these deaths by sex, race, age, and month when the death occurred is shown in Table 1.

Table 1  
*Deaths from Suicide in New Jersey in 1970*

Sex:	males	363	Race:	white	476
	females	144		non-white	31
Age:	0-9	0	Month:	January	43
	10-19	24		February	39
	20-29	80		March	40
	30-39	68		April	45
	40-49	98		May	47
	50-59	92		June	46
	60-69	83		July	38
	70-79	46		August	39
	80-89	14		September	44
	90-99	1		October	43
				November	40
				December	43

The number of suicidal deaths each year has varied from between 500 and 600 over the last eight years but the rate remains low, varying between 7.1 and 9.2 per 100,000 per year (see Table 2). The counties in New Jersey have different rates, varying from 6.5 in Union County to 11.8 in Salem County (see Table 3). There is no apparent association between the age and the sex of the suicides in New Jersey in 1970; neither is there an association between race and month of death, sex and month of death, sex and age, or age and month of death. However, white suicides were significantly older than non-white suicides.

## Attempted Suicide in New Jersey

No records are kept of the number of at-

\*Dr. Lester is Associate Professor of Social Sciences at Stockton State College in Pomona, New Jersey.

†These data were obtained from Miss Anne P. Hal-kovich of the New Jersey Department of Health.



tempted suicides in New Jersey. However, a reasonable estimate can be made. Farberow and Shneidman<sup>3</sup> found, in Los Angeles in 1957, in a survey of all hospitals, clinics, and doctors, that there were about 8 suicide attempts to every completed suicide. Thus, there are probably about 2,000 attempted suicides in New Jersey each year.

Table 2  
*Deaths from Suicide in New Jersey, 1963-1969*

year	number	rate
1969	591	8.1
1968	538	7.5
1967	505	7.1
1966	548	7.9
1965	586	8.6
1964	516	7.8
1963	598	9.2

Table 3  
*Deaths from Suicide in New Jersey by County*

County	Median Rate 1963-1969
Atlantic	8.1
Bergen	6.8
Burlington	8.4
Camden	8.1
Cape May	9.2
Cumberland	10.6
Essex	9.2
Gloucester	7.8
Hudson	7.9
Hunterdon	8.9
Mercer	7.8
Middlesex	7.5
Monmouth	7.4
Morris	9.2
Ocean	11.5
Passaic	7.2
Salem	11.8
Somerset	8.4
Sussex	9.3
Union	6.5
Warren	11.5

The Physician and the Suicidal Individual

The physician frequently comes into contact with suicidal individuals and is often in a good position to evaluate the seriousness of the intent of the person. Many people who complete suicide visit a physician in the few months prior to their death. Inwood and Anderson<sup>4</sup> estimated that 60 per cent of all completed suicides had made a medical contact shortly before their death. Thus, the physician can play an important role in de-

tecting and helping the suicidal person and several recent articles<sup>5</sup> have advised the physician for this task. The lack of control over drugs administered to patients facilitates the person taking his own life. Friedman<sup>6</sup> documented a case where the patient changed a prescription in order to obtain a lethal supply of barbiturates. He suggested that, if the patient is possibly suicidal, the doctor should work together with the pharmacist to ensure that the patient does not acquire an oversupply of drugs.

Robin and Freeman-Browne<sup>7</sup> found that half of actively suicidal patients who were hospitalized had large quantities of drugs at home and that these patients were released without precautions being taken to remove these lethal drugs.

Although a person deprived of drugs can easily turn to an alternative method of killing himself, it would seem appropriate to watch carefully the drugs prescribed to potentially suicidal patients. This, together with the increased awareness of the doctor to cues indicating suicidal preoccupation, may contribute toward the prevention of suicide.

Suicide Among Physicians

There has been concern recently with the incidence of suicide among physicians. Although the suicide rate of physicians is no higher than that of other professional groups, some specialties do have relatively high rates. Psychiatrists have six times the suicide rate of pediatricians, and ophthalmologists have five and a half times the rate of pediatricians. Interns have twice the rate of residents and the faculty of medical schools have three times the rate of residents.

Blachly, *et al.*<sup>8</sup> described the suicidal physician as competitive, compulsive, individualistic, ambitious, a graduate of a high-prestige medical school, with mood swings, a problem drinker or drug user, with a non-lethal physi-

cal illness, and one who feels a lack of restraints from society.

One of the notable findings from Blachly's study was that the relatives of suicidal physicians had often turned for help to fellow physicians but had received little assistance from them. Colleagues of the deceased had often been aware of the problems but had not intervened. In some cases, relatives reported that colleagues exacerbated the problems—for example by buying bottles of liquor for an alcoholic physician. Blachly<sup>8</sup> urged that physicians pay attention to their colleagues who seem to be having problems and endeavour to help them.

Stockton State College

## Bibliography

1. Dublin, L.: *Suicide*. New York, Ronald Press, 1963
2. Douglas, J.: *The Social Meanings of Suicide*. Princeton, Princeton University Press, 1967
3. Shneidman, E. S. and Farberow, N. L.: *The Cry for Help*, New York, McGraw-Hill, 1961
4. Inwood, E. R. and Anderson, M. M.: *GP*, 30:130 (April 1964)
5. Lewis, J. M.: *Texas Med.*, 64:52 (January 1968)
6. Friedman, G. A.: *New York State J. Med.*, 66:3005 (July 1966)
7. Robin, A. A. and Freeman-Browne, D. L.: *Brit. Med. J.*, 3:424 (October 1968)
8. Blachly, P. H., Disher, W., and Roduner, G.: *Bulletin of Suicidology*, Dec: 1, 1968

## Mobile Chest Screening Questioned

The use of mobile equipment for x-raying the general population for tuberculosis and other chest diseases should stop says a new mass x-ray policy statement prepared jointly by the HEW Food and Drug Administration, the American College of Chest Physicians, and the American College of Radiology.

The kind of equipment found in highway vans in many parts of the country is not productive as a screening procedure for chest disease detection, the statement says. This supersedes a 1958 policy declaration by the Surgeon General of the Public Health Service that emphasized that mass chest x-rays should be conducted "selectively" with groups "at high risk of tuberculosis infection." The new policy was dictated "in large part by the fact that tuberculosis is now almost nonexistent in many regions of the country. The use of mobile equipment, which requires relatively higher levels of x-ray exposure than fixed equipment, simply cannot be justified."

The new policy recommends the use of full

size x-ray film when x-ray screening of selected population groups is essential for disease detection. The recommendation is intended to discourage the use of photofluorographic equipment that uses a fluoroscope screen in combination with miniature photographic film. This equipment may expose patients to considerably more radiation than equipment employing x-ray film.

Photofluorographic equipment should be used, the statement says, only if (1) the x-ray image is interpreted by a physician with demonstrated competence in chest x-ray analysis, (2) x-rays and reports can be retained for at least five years for medical diagnosis, and (3) the equipment meets x-ray exposure control requirements of state and federal regulations and recommendations of the National Council on Radiation Protection.

Also stressed is the use of tuberculin skin tests in screening for new cases of tuberculosis. The new policy calls for x-ray follow-up only when the tuberculin reaction is positive.





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Valium® (diazepam)

To help you manage excessive psychic tension

ALSO AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

## Android<sup>®</sup> 5

MUQUETS  
BUCCAL Tabs

Methyltestosterone N.F. - 5 mg.

## Android<sup>®</sup> 10

Methyltestosterone N.F. - 10 mg.

## Android<sup>®</sup> 25

Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpubertal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

**BROWN**

THE BROWN PHARMACEUTICAL CO., INC.  
2500 West 6th Street, Los Angeles, California 90057

*Here is a practical little monograph on a seldom-used but useful, innovative technic.*

# Sialographic Evaluation of Parotid and Submandibular Masses

**Daniel S. Cukier, M.D./Hackensack\***

Most physicians occasionally see patients with masses at or near the angle of the jaw and in the submandibular area. Enlarged lymph nodes, lipomas, fibromas, hemangiomas, branchial cleft, and sebaceous cysts can usually be diagnosed clinically. However, when these masses are near the salivary gland (or when disease of the parotid or submaxillary gland is suspected) sialography is a valuable method in determining the etiology and the extent of pathology. A differential diagnosis of obstruction, inflammatory disease, and neoplasm can be performed with high accuracy. The examination is performed easily as an office procedure, averaging twenty minutes provided a standard and meticulous technic is observed.

The mouth is rinsed with warm water to dilate and cleanse the salivary duct orifices. Supine scout films of the skull are obtained in the anterior-posterior, oblique, and both lateral projections, as well as intra-oral views of the cheek and floor of the mouth.

Gentle massage of the gland reveals the opening to Stensen's duct at the apex of a small papilla opposite the second upper molar tooth and that of Wharton's duct on the papilla under the tongue on either side of the frenulum.

A 0000 sterile lacrimal cannula is gently inserted into the orifice and gradual replace-

ment of wider cannulas follows until the duct allows a 3 probe. An intramedic PE 50 polyethylene catheter, fitted over a blunt #25 Luerlok needle (with its tip extending a centimeter beyond the needle) is introduced into the duct. Lipiodol is injected slowly. An oily contrast agent is preferred since water soluble contrast media can be irritating to the tissues and results in poorer radiographic detail. The patient is requested to signal when glandular discomfort occurs, indicating sufficient contrast medium has been injected. The catheter is removed and a gauze pad is immediately applied to the area and held by the closed mouth to prevent loss of contrast medium during radiography. Anterior-posterior, lateral and oblique x-rays are obtained. The patient then rinses his mouth with warm water, and lemon sucked at this stage serves as a satisfactory evacuant.

## Radiographic Findings

The radiographic appearance of the normal parotid and submaxillary gland is that of a "winter tree"<sup>1</sup> (see Figures 1 and 2).

Infection may change this appearance in one of these ways:

1. Fusiform dilatation of the main duct only (see Figures 3 and 4).
2. Fusiform dilatation of the main duct and glandular ducts. Some cylindrical dilatation of the small ducts and acini may be present (see Figure 5).
3. Spherical dilatation of glandular ducts and acini only (Sialoangiectasis)<sup>2</sup> (see Figure 6).

\*Dr. Cukier is attending radiologist at Pascack Valley Hospital, Westwood, New Jersey.





*Figure 1. Parotid Sialogram (Lateral view). The main duct has a uniform caliber and in the gland arborizes into progressively finer subdivisions.*



*Figure 2. Submaxillary Sialogram (Lateral view). The main duct has a uniform caliber and in the gland arborizes into progressively finer subdivisions.*



*Figure 3.* Parotid Sialogram (Lateral view). Fusiform dilatation of the main duct proximal and distal to a radiolucent stone. This pattern is usually associated with the sudden onset of obstruction due to stone.



*Figure 4.* Anterior-Posterior view in the same patient. Note radiolucent stone.



*Figure 5.* Parotid Sialogram revealing fusiform dilatation of main duct with a long area of narrowing secondary to stricture formation. Note some cylindrical dilatation of the small ducts and acini. This pattern is usually associated with a chronic history of infection.



*Figure 6.* Parotid Sialogram. Note spherical dilatation of glandular ducts and acini without abnormality in the main duct.



*Figure 7.* Parotid Sialogram of a mixed tumor. Note the stretching and narrowing of the glandular ducts.



In the average adult patient, the normal parotid gland will allow the introduction of 1.5 cubic centimeters and the submaxillary gland of 0.5 to 1 cubic centimeter of contrast medium. Patients tolerating 2.5 cubic centimeters or more will almost invariably demonstrate ductal or acinar ectasia.<sup>3</sup> The gland normally empties in five to ten minutes whereas patients with obstructive disease or cancer may retain dye for a longer period of time.

Most obstructive disease due to stones or strictures is located in the main duct. Stones may also be located in the smaller glandular ducts or parenchyma. Obstruction usually occurs when a calculus exceeds 3 millimeters in diameter. Stones are often non-radiopaque. They more commonly occur in the submaxillary area, where they are usually opaque.<sup>4</sup>

Tumors may reveal one more of the following radiographic findings:

- 1. Pressure defect on the main duct altering its course.
- 2. Displacement and "stretching" of the glandular ducts (see Figure 7).
- 3. Erosion of the glandular ducts with a resultant "beaded" appearance.
- 4. Compression with resultant narrowing of the ducts.
- 5. Cavitation resulting in "pooling" of contrast medium.

Radiographic differentiation of benign from malignant tumors of the salivary gland is often difficult. Erosion, compression, or cavitation indicates malignancy.<sup>5</sup>

Clinical Findings

Patients with a painful swelling associated with meals usually have obstructive disease secondary to stone or stricture. Patients with recurrent glandular pain and tenderness and fever will often reveal findings of infection with or without obstruction.

Relatively painless slowly progressive swelling in the presence of a firm gland suggests tumor.

Tumors are more frequent in the parotid gland than in the submaxillary gland in a ratio of approximately 8 to 1. Benign tumors of the parotid gland are found twice as frequently as malignant tumors. In the submaxillary gland benign and malignant tumors occur with equal frequency.<sup>6</sup>

Case Material

Fifty-four sialograms were performed. Age incidence ranged from five years to sixty-nine years. Forty-two of the fifty-four cases were interpreted as positive, and of these, thirty-four cases (approximately 80 per cent) were operated upon. Diagnostic accuracy was 100 per cent in the differentiation of non-neoplastic and neoplastic disease. Those patients not operated on revealed a subsequent clinical course compatible with the radiographic diagnosis.

Table I

Parotid Disease	38 cases	Operated
Normal	7	0
Obstructive	18	18
Non-obstructive	7	2
Neoplastic	6	6

Submandibular Disease	16 cases	
Normal	5	0
Obstructive	6	6
Non-obstructive	5	2

Summary

The clinical findings, while important, are not always a reliable guide in evaluating salivary gland disease. Regional swelling outside the salivary glands due to other causes renders clinical evaluation difficult. A normal sialogram will then identify the extrinsic nature of the disease process. When the etiology is of a salivary origin, sialography will facilitate distinction between infection and neoplasia and a medical or surgical approach. This technic also yields valuable information as to the extent of the pathology. Sialography is conveniently done as an office procedure and is a highly accurate radiographic examination.

## Bibliography

1. Einstein, R. A.: *Surgery, Gynecology, and Obstetrics*, 122:1079 (May, 1966).
2. Schultz, M. D. and Weisberger, D.: *Surg. Clin. of North America*, 27:1156 (October, 1947).
3. Rubin, P. and Holt, J. F.: *American Journal of Roentg.*, 77:575 (April, 1957).
4. Pendegrass, E. P., Schaeffer, J. P., and Hopes, P. J.: *The Head and Neck in Roentgen Diagnosis*. Springfield, Illinois, Charles C. Thomas, 1956 Pp. 1600-1610.
5. Meine, F. J. and Woloshin, H. J.: *Radiol. Clin. of North America*, 8:475 (December, 1970).
6. Foote, F. W. and Frazell, E. L.: *Atlas of Tumor Path.*, Section IV, Fascicle XI, Washington, 1954.

35 Pangborn Place

## Skin, Scuba Diving Not for Everyone

If you're off to some sunny beach for a holiday, and think you're ready to try skin or scuba diving, think twice before you jump into the water.

A Seattle doctor warns that such diving, easy as it looks, is not for everyone. In the December 1971 *Transactions* in the Journal of the American Academy of Ophthalmology and Otolaryngology, Dr. Frank C. Henry of Seattle says you should have a physician examine you to make sure you do not fit in 13 caution categories. They are:

1. Overweight
2. High blood pressure
3. Perforated ear drum
4. Sinus trouble
5. Inability to equalize pressures in your ears
6. Cold or other infection of nose and throat
7. Diabetes or other chronic disease
8. Epilepsy or other nervous disorder
9. Claustrophobia or other emotional problem
10. Head injury
11. Asthma, emphysema, tuberculosis, or other respiratory disease
12. Older than 40 years
13. Use of alcohol or other drugs that dull the senses.

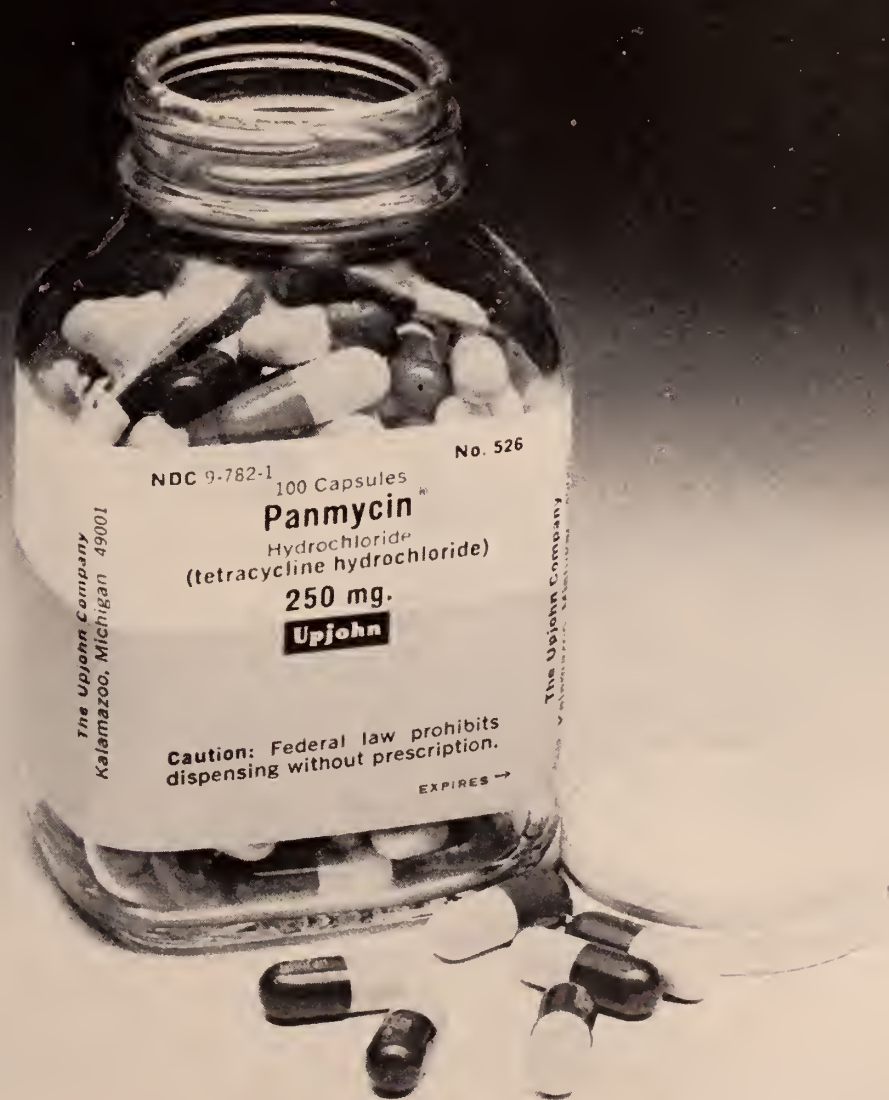
Doctor Henry says that the most general effect of descending under water is the "squeeze." Even "when a diver is 3 feet below the surface, the pressure of the water on his chest is so great that it is difficult to expand his lungs. The "squeeze" may affect other parts of the body such as the face, when a face mask is worn and unequal pressure results due to failure to equalize the pressure differential. Other results of the "squeeze" may be red velvet eyes, due to hemorrhage. Starting

with the first 6 feet under water, a diver must "clear his ears" by blowing, swallowing, or chewing as he descends, just as a passenger does when a plane approaches an airport. If the skin or scuba diver fails to do this, the unequally great pressure on the outside of the ear drum may cause pain and lead to hemorrhage of the eardrum and even of the middle ear. If you dive too deeply without clearing your ears, the eardrum may rupture, letting in cold water. The disorientation which may result can be life-threatening.

If you dive while suffering from a cold, allergic nose, or sinusitis, you may have trouble because your sinuses cannot clear. The resulting pressure inequality can cause "sinus squeeze" that leads to congestion and even hemorrhage. Sometimes, "the diver may surface without pain but finds his mask filled with blood from the sinuses."

Another problem of unequal pressure may be a toothache that results from air being trapped under a filling or other dental restoration. Diving with a scuba tank can be even more worrisome, because this allows you to go deeper and be subjected to increased pressures. Among the dangers to scuba divers are: nitrogen narcosis, akin to drunkenness; oxygen poisoning that can bring on convulsions; carbon dioxide poisoning that causes drowning; lung disorders from not exhaling properly as you ascend; the bends, from coming up too fast. Doctor Henry, a diver himself, says "As man goes deeper and stays underwater longer his problems multiply."

# Upjohn's low-priced tetracycline



## Panmycin<sup>®</sup>

(tetracycline HCl, Upjohn)

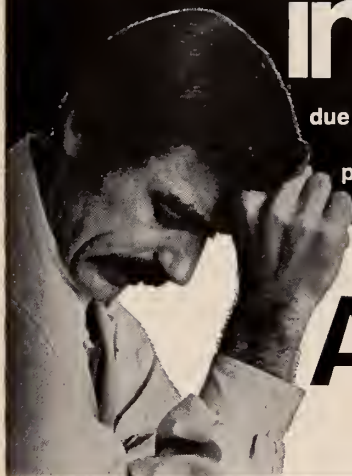
Available as 250 mg capsules and  
tetracycline syrup 125 mg/5 ml

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2142-6





The treatment of

# impotence

due to androgenic deficiency in the American male.


The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

**NEW  
CLINICAL  
STUDY**

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society

# Android<sup>®</sup>

(thyroid-androgen) tablets



**Choice of 4 strengths:**

<p><b>Android</b></p> <p>HIGH POTENCY</p> <p><i>Each yellow tablet contains:</i></p> <p>Methyl Testosterone . . . 2.5 mg. Thyroid Est. (1/6 gr.) . . . 10 mg. Glutamic Acid . . . . . 50 mg. Thiamine HCL . . . . . 10 mg.</p> <p><i>Dose:</i> 1 tablet 3 times daily.</p> <p><i>Available:</i> Bottles of 100, 500, 1000.</p>	<p><b>Android-HP</b></p> <p>HIGH POTENCY</p> <p><i>Each red tablet contains:</i></p> <p>Methyl Testosterone . . . 5.0 mg. Thyroid Est. (1/2 gr.) . . . 30 mg. Glutamic Acid . . . . . 50 mg. Thiamine HCL . . . . . 10 mg.</p> <p><i>Dose:</i> 1 tablet 3 times daily.</p> <p><i>Available:</i> Bottles of 100, 500, 1000.</p>	<p><b>Android-X</b></p> <p>EXTRA HIGH POTENCY</p> <p><i>Each orange tablet contains:</i></p> <p>Methyl Testosterone . . 12.5 mg. Thyroid Est. (1 gr.) . . . 64 mg. Glutamic Acid . . . . . 50 mg. Thiamine HCL . . . . . 10 mg.</p> <p><i>Dose:</i> 1 or 2 tablets daily.</p> <p><i>Available:</i> Bottles of 60, 500.</p>	<p><b>Android-Plus</b></p> <p>WITH HIGH POTENCY B-COMPLEX AND VITAMIN C</p> <p><i>Each white tablet contains:</i></p> <p>Methyl Testosterone . . 2.5 mg. Thyroid Est. (1/6 gr.) . . 15 mg. Ascorbic Acid (Vit. C) . 250 mg. Thiamine HCL . . . . . 25 mg. Glutamic Acid . . . . . 100 mg. Pyridoxine HCL . . . . . 5 mg. Nicotinamide . . . . . 75 mg. Calcium Pantothenate . 10 mg. Vitamin B-12 . . . . . 2.5 mcg. Riboflavin . . . . . 5 mg.</p> <p><i>Dose:</i> 2 tablets daily.</p> <p><i>Available:</i> Bottles of 60, 500.</p>
--	--	--	---

**Double-Blind Study and Type of Patient:**

100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Monticeno, P. and Evenglette, J. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:59, 1956. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Telford, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:5, 1952. 4. Hellman, L., Bradley, M. L., Zimetz, E., Fukushima, D. K., and Salinger, T. F. Thyroid-androgen interrelations and the hypohyalesteremic effect of androstereone. J Clin Endocr 19:536, 1959. 5. Farris, E. J., and Cattan, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:853, 1958. 6. Osel, A., and Farrar, G. E. United States Dispensary (ed. 25). Lipincott, Philadelphia, 1959, p. 1432. 7. Marshall, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 75-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057

Here is a timely warning against complacency on what could easily be a "routine" subject.

# Ophthalmia Neonatorum Is Still With Us

Norman W. Zanger, M.D. and  
Richard Chopin, M.D./Newark\*

Silver nitrate prophylaxis is the time-honored procedure for the prevention of gonococcal ophthalmia neonatorum. In spite of previous silver nitrate prophylaxis, the diagnosis of gonococcal ophthalmia neonatorum must be considered in all conjunctivitis of the newborn.

The original recommendation for the use of silver nitrate prophylaxis for ophthalmia neonatorum was made in 1881 by Crede<sup>1,2</sup>. In one year he had treated 200 newborns prophylactically with silver nitrate, without a single case of ophthalmia neonatorum. In a Leipzig hospital, from 1874 to 1880, Crede found that 226 cases of ophthalmia had occurred among 2,266 newborn infants. In the same hospital, from 1880 to 1883, only four cases of ophthalmia neonatorum occurred in 1,160 newborns who were treated prophylactically with a 2 per cent solution of silver nitrate. The Crede method of prophylaxis rapidly became accepted in Europe and America, modified only in that the concentration of silver nitrate was reduced to one per cent.<sup>1</sup>

Recently,<sup>3</sup> the New York City Health Department reviewed gonococcal ophthalmia prophylaxis in the newborn in all hospitals in New York City, during the years 1956, 1957, and 1958. Hospitals were permitted to omit prophylaxis under controlled conditions during this period. Results are summarized in Table I.

TABLE I

New York City 1956-1958: 472,580 Infants:  
49 Cases of Gonococcal Ophthalmia Neonatorum

# of Cases of GON	Sample	Prophylaxis	Per 100,000
1. 22	86,407	None	25.5
2. 1	14,042	Saline	7.5
3. 17	258,621	AgNO <sub>3</sub>	6.5
4. 9	80,311	Local Antibiotic	11.2
5. 0	33,199	50,000u Pen I.M.	0.0

Modified from Greenberg, M. and Vandow, J. E. *American Journal of Public Health*. 51:836-845, 1961

In one particular hospital, of 7,217 infants given silver nitrate prophylaxis, there were two cases of ophthalmia neonatorum (0.28 per 1000). In the same hospital,<sup>3</sup> eight cases were diagnosed in 1,996 infants receiving no prophylaxis (4 per 1000).

Pearson<sup>4</sup> reported on 67,000 newborns observed over a ten year period (1946 to 1956). All of these infants had received prophylaxis with 1 per cent silver nitrate. A member of the house staff or a medical student held the newborn's eyes open while a nurse administered the silver nitrate solution. Forty cases of gonococcal ophthalmia were noted in this sample. One developed in an infant on whom the resident had demonstrated the proper way to administer silver nitrate drops, for some medical students. *Non-contact of the drug with the eye* and *non-utilization of the drug* were obviated as factors for failure as a result of the method of administration of the silver nitrate drops used in this study.

\*Dr. Zanger is Pediatric Resident and Dr. Chopin is Assistant Attending Ophthalmologist at the Newark Beth Israel Medical Center.

Pearson<sup>4</sup> reported a twin birth where the first born became infected and the second did not. This points up the probable role of bacterial concentration as a factor for infection. This was also suggested in the New York City Health Department Study,<sup>3</sup> where one noted a frequency of 7.1 per 100,000 of gonococcal ophthalmia when saline wash was the sole method of prophylaxis, as compared to a rate of 25.5 per 100,000 when no prophylaxis was used. (See Table 1) Today, 48 of 50 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands require the use of a prophylaxis in the eyes of the newborn. Silver nitrate was either required or permitted by all of them.<sup>5</sup>

### Case One

A full-term female infant, the product of a normal spontaneous delivery, was noted at the age of four days to have a bilateral conjunctival discharge. A specimen for culture was immediately taken, and the patient was placed on Neosporin® ophthalmic ointment and Dacriose® irrigation to both eyes. The child had received 1 per cent silver nitrate prophylaxis one minute after birth.

After two days, the conjunctivitis had increased in severity. Ophthalmologic consultation was obtained. The patient was noted to have severe bilateral purulent conjunctivitis. There was no necrosis of the conjunctiva, or corneal involvement. The patient was immediately started on 10 per cent sodium sulfacetamide eye drops every hour and 0.5 per cent chloromycetin eye drops every hour. The next day the conjunctivitis of both eyes was markedly improved. The original conjunctival cultures yielded *N. Gonorrhea*, and aqueous penicillin 65,000u I.M., every 12 hours, was added to the treatment regimen. The conjunctivitis improved rapidly, topical medication was gradually reduced, and all medication was discontinued after a five day course. A repeat conjunctival culture taken two days after initiation of sodium sulfacetamide and chloromycetin topically revealed no growth.

### Case Two

A full-term female, product of a normal spontaneous delivery, developed a bilateral conjunctivitis six days after birth. She was a healthy female with no abnormalities other than a bilateral purulent conjunctivitis with an extremely copious discharge. The corneas were not involved. Silver nitrate prophylaxis had been administered one minute after birth. A conjunctival culture was obtained and the patient was immediately placed on systemic penicillin and topical 10 per cent sulfacetamide and 0.5 per cent chloromycetin eye drops. The conjunctivitis rapidly cleared. The culture revealed *N. Gonorrhea*. Another culture three days later was negative. The patient was kept on medication for seven days.

Although silver nitrate prophylaxis has been

in use for almost a century, its effectiveness has been questioned frequently. In reviewing the records of 28,000 infants who had received silver nitrate prophylaxis, Lehrfield<sup>3</sup> found 632 cases of ophthalmia, thirty per cent of these were verified as gonococcal.

In a review of the literature (1948 to 1966), Barsam<sup>1</sup> concluded that a significant reduction of gonococcal ophthalmia neonatorum was noted when silver nitrate prophylaxis was administered. The highest rates<sup>4</sup> for those receiving silver nitrate prophylaxis was 59.5 per 100,000. Pearson's study<sup>4</sup> again underscored the fact that silver nitrate prophylaxis was not 100 per cent effective.

A negative gonococcal smear during pregnancy does not preclude the diagnosis of gonococcal ophthalmia neonatorum in the infant. Pearson<sup>4</sup> cited a case where the mother had coitus with the infected father the night before delivery. In the pregnant women, low grade gonococcal infection may be completely asymptomatic and therefore present no stimulus for repeat gonococcal testing.<sup>6</sup> As a rule, gonorrheal infection remains latent until after delivery, when gonorrheal oophoritis, salpingitis, endometritis, and pelvic peritonitis may occur.<sup>7</sup>

The low rate of infection noted when saline wash alone was used as prophylaxis<sup>3</sup>, and the report of a twin birth where the first twin was infected and the second was not<sup>4</sup>, indicates that further study is needed to define the role of bacterial dilution as a determining or contributing factor for the effectiveness of silver nitrate prophylaxis.

### Summary and Conclusions

(1) Silver nitrate prophylaxis has reduced, but not eliminated gonococcal ophthalmia neonatorum.

(2) Gonococcal smears and cultures should be obtained from the mother routinely upon admission for delivery, as well as during pregnancy.



(3) Due to the possibility of corneal scarring, ophthalmological consultations should be obtained in all cases.

(4) There still exists a need for a long-term comparative study of prophylactic methods for ophthalmia neonatorum.

(5) The application of silver nitrate prophylaxis should be done with great care in spite of the "routine" nature of the procedure and relatively infrequent occurrence of gonococcal ophthalmia neonatorum.<sup>4,8</sup>

## Bibliography

1. Barsam, P. C.: *New England Journal of Medicine*, 274:731 (1966).
2. Crede, C. S. F.: *Arch. Gynak.* 17:50 (1881).
3. Greenberg, M. and Vandow, J. E.: *American Journal of Public Health*, 51:836 (1961).
4. Pearson, H. E.: *American Journal of Obstetrics and Gynecology*, 73:805 (1957).
5. Ophthalmia Neonatorum Control Laws (Chart). United States Department of Health.
6. Schofield, C. B. S.: *Lancet*, 2:1182 (1969).
7. Greenhill, J. P.: *Obstetrics* 13th Edition, Philadelphia, Saunders, 1965.
8. Osterlund, K., et al.: *Ann. Paediat. Fenn.*, 14:23 (1968).

201 Lyons Avenue

## Rising Self-Esteem Helps Depressed People

A tangible demonstration to a depressed patient that he can successfully attain a stated goal can lessen his pessimism, improve his self-esteem, and enhance motivation. This frequently made clinical observation now has been tested by research scientists supported in part by the National Institute of Mental Health of HEW's Health Services and Mental Health Administration. Their report, "Differential Effects of Success and Failure on Depressed and Nondepressed Patients," was published in *The Journal of Nervous and Mental Disease*, 1971.

The hypothesis tested was that the depressed patient is so sensitive to positive or negative information about himself that a minor success or failure even on a seemingly irrelevant task would affect his self-evaluation, expectancies, and performance. Subjects were 40 male patients at two Philadelphia psychiatric outpatient clinics.

Ten of the patients were assigned in a card-sorting experiment to a "success" producing condition (i.e., they were told they had succeeded), and 10 others were assigned in the experiment to a "failure" condition, (i.e.,

they were told they had failed). A control group of 20 non-depressed patients was similarly divided. The depressed patients were more pessimistic from the outset about doing well, and when asked how they had done, gave lower ratings to their own performance than did the nondepressed control groups.

However, the researchers found that despite their negative outlook, the actual output of the depressed groups was as good as that of the control group.

After the first test, a second and more difficult card-sorting task was assigned. Depressed patients who had been told that they had succeeded on the first test showed more optimism, higher goals, and gave a better performance than did those who thought they had failed. On the other hand, nondepressed patients did markedly better on the second round after being told they failed the first.

"Concrete, favorable feedback regarding specific performance not only improves the depressed patient's outlook and level of aspiration, but also can increase his productivity," concluded the investigators.

# Upjohn's low-priced erythromycin



**E-Mycin<sup>®</sup>**  
(erythromycin, Upjohn)  
Available in 250 mg tablets

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2141-6

# Hand, Foot, and Mouth Disease in Southern New Jersey, 1971

---

**Richard R. Gove, M.D./Brant Beach**

Hand, foot, and mouth disease in epidemic proportions has been noted in the literature. This group of lesions, in association with enanthem, has been attributed to the Coxsacke Group A virus, with a high proportion of them subtype A16, A10, and A5. The first recorded outbreak was in Toronto in 1957. Since then there have been five recorded epidemics, England 1960; California, 1961; Arizona, 1965; and Australia 1966. In the summer of 1971, an epidemic of Hand, Foot, and Mouth disease occurred in the seashore community of Long Beach Island, in southern New Jersey. Sixteen documented cases were reported in a six-week period from July to September. Highest incidence was between the ages of 9 and 25 years, males and females being affected almost equally. The youngest patient was 14 months and the oldest 30 years of age.

The clinical picture was malaise, sore throat, and, occasionally, fever. These symptoms preceded as well as accompanied the skin lesions. Three patients gave a history of mild diarrhea and abdominal discomfort prior to the eruptive lesions. Red papules developed first, followed by a grayish vesicle in the center. Most lesions appeared within two or three days of each other, although the papules on the plantar region of the feet appeared later

in some cases. The lesions in the mouth consisted of ulcers, varying in number from one to fifteen. They generally arose on the tongue, lips, gingiva, inner cheek, and fauces. Unlike herpangina, (where lesions are, for the most, confined to the posterior edge of the palate and on the uvula, tonsils, and pharynx) almost no vesicles were found within these areas. Most complained of difficulty in eating, as well as cosmetic appearance. Petechiae were sometimes found in the gingiva and palate. The eruptions on the feet and hands almost never ulcerated, but did retain the grayish center with an erythematous border. Not all patients had lesions on the hand, mouth and feet, although the oral ulcers were always present. Incubation period was between three and seven days. Most patients were free of symptoms within two weeks.

Although no viral cultures were done (due to the lack of suitable laboratory facilities) all sixteen cases were classic pictures of the hand, foot, and mouth syndrome.

## Summary

A large outbreak of hand, foot, and mouth disease occurred in southern New Jersey in the summer of 1971. The symptoms were the same as those described in previous areas of outbreak with the exception that young adults seemed the prime age group rather than younger children.

4603 Long Beach Boulevard



*A reminder of the days when our Society actually issued a license to practice medicine and surgery. New Jersey was one of the states who, in 1847, joined some others to form the American Medical Association.*

### A Medical Diploma of 1820

Morris H. Saffron, M.D., Ph.D., Passaic\*

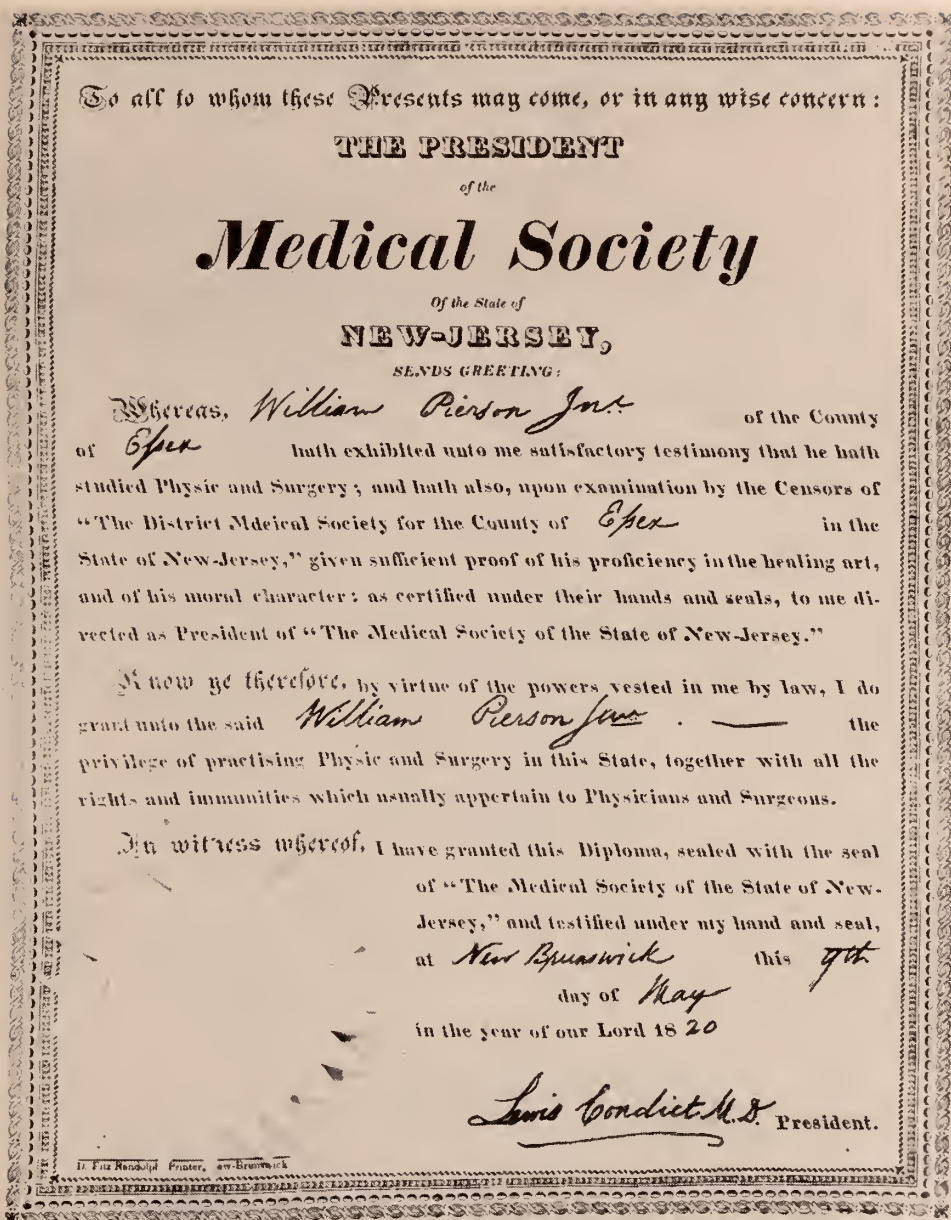
A recent gift to the archives of The Medical Society of New Jersey is a document of considerable historic interest, bringing together the names of two early nineteenth century luminaries, both of whom served our Society with unusual distinction. In itself the document—a diploma issued at New Brunswick on May 9, 1820 (see figure)—would seem to be rare. No other example has as yet come to our attention, and this particular form of diploma probably remained in use for a relatively short period of time.

In 1816 the legislature of New Jersey renewed the incorporation of the Medical Society as a "body politic," and two years later provided for the establishment of constituent societies (district, later county), empowering these to conduct the examination of all applicants for the practice of medicine, including physicians who already held the medical degree. The recommendation of the district society was then to be forwarded to the State Society for final action. That this system was not without pitfalls in a period of slow communications can be seen in the case of the notorious Waldo Brown, who having been disqualified in 1826 by the censors of the Morris County Society, proceeded, without divulging his previous failure, to have himself re-examined, this time successfully, by the censors of the Essex County Society. The row brought on at the state level by this bit of chicanery led to an impassioned plea by Dr. Lewis Conduct, the signer of our diploma, and an amendment to the Bylaws, permitting the Society "to revoke the license of any person who shall have obtained the same through fraud, or in violation of any of the requirements of this act." It will be noted from our diploma of 1820 that al-

though the Medical Society could issue licenses to practice medicine and surgery, it still had no authority to grant the medical degree, and indeed it was not until 1825 that the legislature formally conceded this right to our Society.

The signer of our diploma, Lewis Conduct (1773-1862), was a member of one of the best-known medical families with which our state has been blessed. Having served an apprenticeship with Dr. Timothy Johnes in his native community of Morristown, Dr. Conduct later attended lectures at the University of Pennsylvania from which he received the medical degree in 1794. Returning at once to practice in Morristown he soon gained recognition as a capable, progressive, and conscientious practitioner. He may well have been the first New Jersey physician to adopt Jenner's method of vaccination, introduced into this country (1800) by Benjamin Waterhouse of Boston, an intimate friend of Dr. Conduct. By inoculating his own two-year old daughter, first with cowpox vaccine and later with small-pox matter, Dr. Conduct performed a signal service in encouraging skeptics to adopt this new procedure. But Dr. Conduct was soon to find himself equally at home in the political arena. Having already served from 1805 to 1811 in the State legislature, he was elected to Congress one year after serving his first term as President of our Society (1810-1811). In Congress he soon made his voice heard denouncing the miserable treatment of American sailors, impressed into the British navy in the prelude to the War of 1812. He also advocated immediate emancipation of the slaves, at the same time encouraging the movement for Negro colonization in Africa. After three terms in Congress he returned to New Jersey

\* Dr. Saffron is Archivist-Historian, MSNJ



Medical Diploma of 1820

where he was soon elected to a second term as our Society's president (1819-1820). A man of boundless energy, Dr. Condict again served five successive terms in Congress (1821 to 1833), and was a member of the commission appointed to resolve the long-standing boundary dispute between New Jersey and New York. He also served as trustee of the College of New Jersey (Princeton) for almost half a century and as the first president of the Morris and Essex Railroad (1835). Dr. Condict's

devotion to our Society remained unimpaired by age, and he continued to attend the annual meetings until shortly before his death.

The recipient of our diploma, William Pierson (1796-1882) was the scion of another celebrated medical dynasty which for over a century held sway in the Orange mountain area. The son of Dr. Isaac Pierson (1770-1883), William was named after his father's brother, and the style of Junior noted on our diploma

may have been retained until his uncle's death. Since his own son was also named William (1830-1900) our diploma is useful in dispelling some confusion which has arisen through this duplication of names. It is worthy of note that all three generations of this distinguished family provided a president for our Society.

William Jr. studied medicine at the University of Pennsylvania before transferring in 1817 to the College of Physicians and Surgeons in New York, from which school, however, he did not graduate. In 1816 he had already been accepted as a founding member of the Morris County Medical Society, of which Lewis Conduct had been elected the first president. Our diploma was therefore given to confirm his status in keeping with the legislation of 1818. Like Dr. Conduct, William Pierson soon made himself a powerful force for progress in the medical life of New Jersey, as well as in politics. As early as 1822 he helped compile a report to the Standing Committee of our Society in which he denounced the adulteration of drugs, especially cinchona, by unprincipled and unsupervised tradesmen. Five years later he returned to this problem, advocating as a drastic solution that the dispensing of important drugs be restricted to licensed physicians. In 1847 he was selected as one of the five representatives from New Jersey to attend the organization meeting in Philadelphia of the American Medical Association. An ardent advocate of the importance of reporting communicable diseases and vital statistics, he represented our Society at a meeting of the Quarantine Convention held in New York to propose measures to control the many epidemics which continued to ravage the coastal cities. He also served as mayor of Orange, sheriff of Essex County, and as a State Assemblyman (1837 to 1838). In Trenton, he spoke

for his constituents in opposing the proposed ship canal across the Newark meadows.

The social conscience of this remarkable man is shown through his increasing concern with medical jurisprudence and forensic medicine. Dr. Pierson seems modern in his views on such unpopular subjects as abortion, child abuse, adoption, and state care of the abnormal child. Of more practical interest, in those pre-Pasteur days, was his excellent review of hydrophobia in which he advocated the immediate excision of all bite wounds caused by suspected animals. Finally, it is pleasant to note that when our Society celebrated its first centennial Dr. Pierson was honored by being selected to relate the story of its first hundred years. Having been elected President for the term 1869-1870 he was signally honored two years later by being granted another diploma, this one bearing the coveted but rarely granted degree of Doctor of Medicine.

We are deeply grateful to the donor, Mrs. William D. Pierson of Connecticut, for this valuable gift, and to Mr. and Mrs. Herman W. Liebert of New Haven who brought the diploma to my attention. Mrs. Liebert (née Pierson) is a lineal descent of Dr. William; Mr. Liebert is curator of the Beinecke Library of Rare Books, Yale University.

## References

- Wickes, Stephen: *History of Medicine in New Jersey and of its Medical Men* (Newark, Dennis Company, 1879).
- Rogers, Fred B. and A. Reasoner Sayre: *The Healing Art* Trenton, The Medical Society of New Jersey, 1966
- Rogers, Fred B.: "Medical Degrees in New Jersey." *J. Med. Soc. N. J.* (1953) 50:496 (with bibliography)
- Rogers, Fred B.: "'Medical Doctor' Degrees of New Jersey" *J. Med. Soc. N. J.* (1956) 53:327
- Biographical Directory American Congress 1774-1961* (Washington, D. C. 1961) "Lewis Conduct," p. 761

**Patronize Our Advertisers**  
They Merit Your Support



---

# NEW JERSEY DOCTORS' NOTEBOOK

---

## Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the 1972 Annual Meeting in Atlantic City. Detailed minutes are on file with the secretary of your component society. Following is a compilation of significant actions.

### May 5, 1972

*Seminar on Drug Abuse* . . . Authorized the attendance (with expenses paid) of Granville Jones, M.D., a member of the Special Committee on Drug Abuse, to attend a seminar on drug abuse sponsored by the National Research Council of the National Academy of Sciences, to be held in Ann Arbor, Michigan, May 22 to 24, 1972.

*Nominations for AMA Councils and Committees* . . . Approved the names submitted by the Ad Hoc Selection Committee for Nominations for AMA Councils and Committees for the positions indicated and directed that they be forwarded (together with supporting curricula vitae) to the Chairman of the Committee on Personnel of AMA Board Councils and Committees, with a copy to the Executive Vice President of the AMA:

Council on Drugs	Edward A. Wolfson, M.D., Newark
Council on Food and Nutrition	Harvey P. Einhorn, M.D., South Orange
Council on Legislation	Meyer L. Abrams, M.D., Willingboro John J. McGuire, M.D., Newark
Council on Mental Health	Robert S. Garber, M.D., Belle Mead
Committee on Alcoholism and Drug Dependence	Michael Shenkman, M.D., Westwood
Council on Occupational Health	Delma W. Caldwell, M.D., Linden Mathilda R. Vashak, M.D., New Brunswick
Council on Scientific Assembly	Arthur Bernstein, M.D., Maplewood
Committee on Cutaneous Health and Cosmetics	Emanuel M. Satulsky, M.D., Elizabeth

Committee on Medical Aspects of Automotive Safety  
R. Winfield Betts, M.D., Mount Holly  
Sheldon Feinberg, M.D., Hillsdale

Committee on Medical Aspects of Sports  
Max Novich, M.D., Perth Amboy

Committee on Medicine and Religion  
Watson E. Neiman, M.D., Riverton

Committee on Medicolegal Problems  
Edwin H. Albano, M.D., East Orange

*Retiring Board Member* . . . Gave a rising vote of appreciation to Emanuel M. Satulsky, M.D., on his retirement from the Board of Trustees.

*Expression of Appreciation* . . . Expressed its appreciation to E. Vernon Davis, M.D., retiring President, for his many accomplishments during his term as President.

### May 9, 1972

*Introduction of New Member* . . . Welcomed Howard D. Slobodien, M.D., 3rd District, as a member of the Board of Trustees.

. . . Noted that John J. McGuire, M.D., was elected to the office of Second Vice-President; that Louis F. Albright, M.D., had been re-elected to the office of Secretary; and that Samuel J. Lloyd, M.D., had been re-elected to the office of Treasurer.

*Reorganization of Board* . . . Re-elected A. Guy Campo, M.D., as Chairman of the Board for 1972-1973; elected David Eckstein, M.D., as Secretary of the Board for 1972-1973; agreed to continue meeting regularly at 10:45 a.m. on the third Sunday of each month in the Executive Offices (meetings subject to cancellation should the agenda prove insufficient); re-elected David Eckstein, M.D. as a Board of Trustees member of the Committee on Finance and Budget for a three-year term (1972-1975); re-elected Frank Y. Watson, M.D. to membership on the Committee on Physicians' Relief Fund for a three-year term (1972-1975).

*Reappointment of Salaried Personnel . . .* Reappointed for 1972-1973, at the salaries set forth in the adopted budget, all salaried personnel not under individual contract.

. . . Commended the staff and recorded its appreciation and gratitude for the success of the 1972 Annual Meeting.

*Liberalization of Abortion Laws—Resolution #2 . . .* Adopted . . . Directed that a copy of the Substitute Resolution for Resolution #2, with a covering letter, be sent to the Governor, the President of the Senate, and the Speaker of the General Assembly.

*Nominating Procedure—Resolution #4 . . .* Not Adopted—Referred to Board . . . Directed that the President be empowered to establish an ad hoc committee to investigate the nominating procedure and to appoint the committee's personnel.

*Survey of Methods to Increase AMA Membership—Resolution #6 . . .* Adopted . . . Directed that the resolution be referred to the component societies for implementation.

*Membership Opinion Survey on Various Subjects—Resolution #26 . . .* Adopted as amended . . . Referred the resolution to the Council on Public Relations with the request that the Council schedule a meeting early in June so that a report can be considered at the next meeting of the Board.

*"No Fault" Professional Liability Insurance—Resolution #9 . . .* Adopted as amended . . . Directed that the resolution be referred to the Committee on Medical Defense and Insurance.

*Blue Cross-Blue Shield Group Enrollment—Resolution #27 . . .* Adopted as amended . . . Directed that the resolution be referred to the Committee on Medical Defense and Insurance.

*Accreditation of Education—Resolutions #14 and #15 . . .* Substitute Resolution . . . Directed that the substitute resolution for resolu-

tions #14 and #15 be referred to the Council on Legislation.

*Alcoholism Detection and Prevention Clinics Resolution #16 . . .* Adopted . . . Directed that the Executive Director and the Chairman of the New Jersey Delegation to the AMA prepare a resolution on this subject for submission to the AMA for consideration at its forthcoming annual meeting.

*Drug Abuse Registry—Resolution #17 . . .* Adopted . . . Directed that a copy of the resolution be sent to the Director of the Division of Narcotic and Drug Abuse Control.

*Improper Denial of Physicians' Claims Under Medicaid—Resolution #18 . . .* Adopted as amended . . . Directed that a copy of the resolution be sent to the Commissioner of the Department of Institutions and Agencies.

*Environmental Health—Resolution #22 . . .* Adopted . . . Directed that a copy of the resolution be sent to the Department of Environmental Protection.

*Fitness to Drive—Resolution #23 . . .* Adopted . . . Directed that a copy of the resolution be sent to the Director of the Division of Motor Vehicles.

*Sanitary Disposal of Sewage from World Trade Center Building in New York City—Resolution #29 . . .* Adopted . . . Directed that a copy of the resolution, with a covering letter, be sent to the New Jersey Commissioner of the Department of Environmental Protection, the New York Port Authority, the New York City Department of Health, and the Medical Society of the State of New York.

*AMA Annual Convention (1972) . . .* Confirmed authorization for the following to attend the 1972 AMA Annual Convention in San Francisco, June 18 to 22, with expenses paid at a per diem of \$50: President, President-Elect, Executive Director, six regular delegates, and six alternate delegates.

*AMA Clinical Convention (1972)* . . . Confirmed authorization of the following to attend the 1972 AMA Clinical Convention in Cincinnati, November 26 to 29, with expenses paid at a per diem of \$50: President, President-Elect, Executive Director, six regular delegates, and six alternate delegates.

*Retired Board Member* . . . Directed that a letter of appreciation be sent to George E. Barbour, M.D., (who had requested that he not be nominated to serve as a Trustee from the third district) for the many services he rendered while a member of the Board of Trustees.

---

## Caution on HMO's

The American Medical Association has urged Congress to observe a "flashing yellow light of caution" before rushing into large-scale HMO programs. John R. Kernodle, M.D., Burlington, North Carolina, Vice-Chairman of the AMA Board of Trustees, and Russell B. Roth, M.D., Erie, Pennsylvania, President-Elect of the AMA, told the Subcommittee on Health and Environment that the AMA favors a pluralistic system of medical care. "Different methods of medical care should be allowed to compete freely in the marketplace to satisfy varying public demands. No one method of medical care can satisfy all. No one method of care should be imposed and no one method should be so heavily subsidized or otherwise encouraged as to undermine the working of free choice. We do feel that HMO's merit trial. But the trial should be limited. Possible benefits to health in terms of service rendered and their efficiencies in terms of cost reduction should then be objectively measured against the possible shortcomings and deficiencies."

Dr. Kernodle noted that the Administration has made 110 planning and development grants, and is requesting \$27 million in a supplemental budget for this year and \$60 million next year to speed these problems. He warned that HMO's could represent a giant step backwards to a type of contract medicine the public rejected half a century ago. Even in recent years contract medicine has had a sobering record of failure—the passing of the Rip Van Winkle group in Hudson, New York, declining enrollments in the Community Health Association in Detroit and the In-

ter-County Hospital Plan of Johnstown, Pennsylvania. All these signals flash a caution light and "we question that the type of practice offered in an HMO will attract a substantial segment of the medical profession." Dr. Kernodle said further, "I hope I have suggested that there is much reason to proceed with caution. We should first gain experience with test models and see if they fly before we order a whole fleet."

"The federal government has already made some 110 grants for planning and for feasibility studies for HMO's. But the results of these studies and plans are as yet unknown in terms of the quality and extent of the services which can be provided, their accessibility to beneficiaries, the cost of providing them, and their acceptability to consumers and providers alike."

"We believe that the present range of federally funded experimentation is adequate to provide most of the desired answers in a few years. But, we believe that the announced goal of having HMO's available to 80 per cent of the population within a decade is indefensible overpromise."

### Use of M.D. or D.O. Title

The State Board of Medical Examiners requires that all MD's and DO's identify themselves in accord with the degree by which they were awarded the New Jersey license. The Board says that the physician may be cited for a violation if he does not adhere to this requirement.



# Medical College Notes

Stanley S. Bergen, Jr., M.D.  
President, CMDNJ

Nationally there is great interest in the recent increase in applications to medical and dental schools. This trend is similar to the one experienced in the early 1950's and shows no sign of leveling off or changing its direction in the immediate future. In 1971, some 29,000 individuals filed 209,000 applications for the entering class in the fall of 1971, for 12,300 positions at United States medical schools.

The Graduate School of Biomedical Sciences received 45 applications and 30 of these have been accepted for doctoral study at the school in Newark. Ten special students were also accepted for non-degree study in the biomedical sciences. The New Jersey Dental School received 1,025 completed applications from candidates for 64 openings and thus far 61 students have been accepted to begin the first year of their dental education in July of 1972. Although there is some obvious duplication, the New Jersey Medical School received 2,438 applications and Rutgers Medical School, 2,300 applications for 110 and 88 positions respectively. Thus far, 109 students have been accepted at the New Jersey Medical School and 82 at the Rutgers Medical School division of the College. The admissions committees at the College's four schools faced a formidable task during the past several months interviewing and evaluating over 5,800 candidates for the 302 available openings—a ratio of 159 candidates for each position. Two hundred eighty-two students have been accepted at this time.

In all four schools the overwhelming predominance of successful applicants emanated from New Jersey (approximately 80 per cent), with New York and Pennsylvania following, in that order. This augers well for the College's potential for contributing trained physicians to fulfill New Jersey needs. The geographic composition of the classes will be as follows:

Graduate School of Biomedical Sciences  
24 of 30 from New Jersey

New Jersey Dental School	
45 of 61 from New Jersey	
New Jersey Medical School	
93 of 109 from New Jersey	
Rutgers Medical School	
58 of 82 from New Jersey	
Minority Students:	
New Jersey Dental School	10
New Jersey Medical School	30
Rutgers Medical School	17
Female Students:	
Graduate School of Biomedical Sciences	6
New Jersey Dental School	4
New Jersey Medical School	27
Rutgers Medical School	23

The great divergence of background has become increasingly evident over the last few years. At one time it was generally accepted that pre-medical and pre-dental education centered in the sciences, with most undergraduate candidates matriculating from departments of chemistry, biology, and physics. This year our students have taken majors in such fields as history, electrical engineering, economics, business administration, and mathematics. One accepted candidate is a graduate of the U.S. Naval Academy, two are former nurses, two are former medical technicians.

Approximately 5 to 10 per cent of our applicants represent re-application to a professional school after additional study or graduate work. Forty-three applicants to the Dental School previously or concurrently applied to medical school. Four of these applicants were accepted and two have enrolled to begin in July. Many of our successful applicants already possess doctoral or masters level degrees, again in very divergent fields of interest.

There is no doubt that many qualified students have, of necessity, been rejected due to the intense competition this year. This is unfortunate, but we hope it will at least in part be remedied by continued expansion of all our schools over the next few years, by the acceptance of advance-standing students, and by our "fifth channel clinical clerkship." We look forward with great expectation to our new students who seem to be the most highly qualified candidates, as a group, yet to be accepted by the College.



**Pink isn't exactly his color,  
but he loves it for a change.**

**WinGel<sup>®</sup>**

aluminum-magnesium hydroxides  
mint-flavored antacid liquid and tablets

For your ulcer and ulcer-prone patients...  
a refreshing break from the  
boring sameness of white antacids.

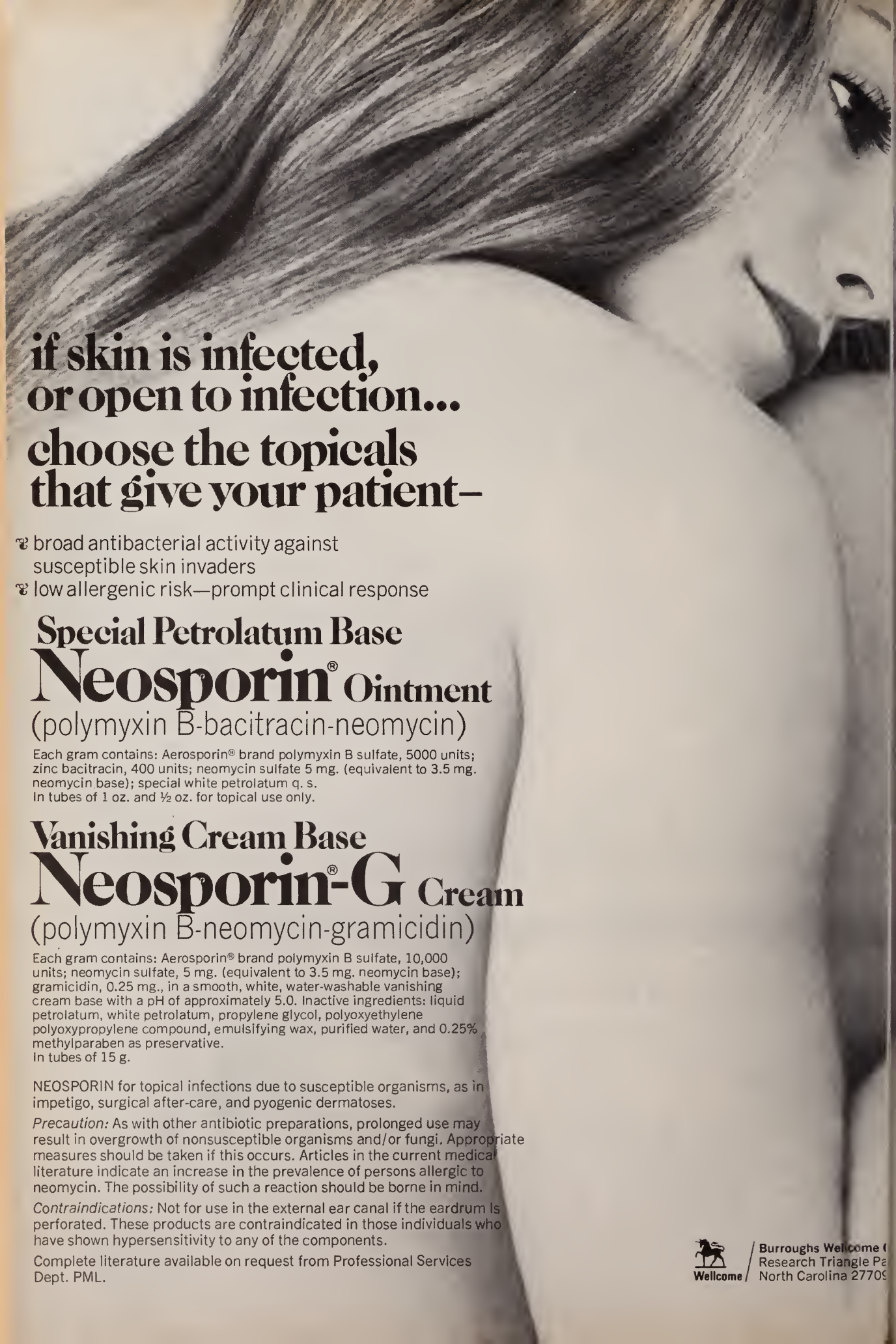
- pleasing mint flavor
- non-gritty texture
- formulated to avoid  
constipation and laxation



**Winthrop**

WINTHROP LABORATORIES  
NEW YORK, N.Y. 10016





**if skin is infected,  
or open to infection...  
choose the topicals  
that give your patient—**

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

**Special Petrolatum Base**  
**Neosporin<sup>®</sup> Ointment**  
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

**Vanishing Cream Base**  
**Neosporin<sup>®</sup>-G Cream**  
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin<sup>®</sup> brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.  
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

**Precaution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709



# Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during May and June 1972:

	1971	1972
	May	May
Aseptic meningitis	5	16
Post infectious encephalitis	1	0
Hepatitis: Total	307	308
Infectious	237	234
Serum	70	74
Malaria: Total	6	1
Military	5	0
Civilian	1	1
Meningococcal meningitis	4	3
Mumps	246	44
German measles	126	329
Measles	381	24
Salmonella	64	177
Shigella	26	60

	1971	1972
	June	June
Aseptic meningitis	8	15
Primary encephalitis	4	9
Hepatitis: Total	338	356
Infectious	255	224
Serum	83	132
Malaria: Total	13	2
Military	13	2
Civilian	0	1
Meningococcal meningitis	4	2
Mumps	130	88
German measles	91	233
Measles	200	9
Salmonella	61	110
Shigella	18	13

## Viral Respiratory Illness

Last December the base physicians at a military training facility in New Jersey noted a sudden increase in the number of recruits with upper respiratory illness. Training was suspended on December 10, because of the large number of ill recruits. Epidemiologic studies revealed that on that day more than 40 recruits became ill with upper respiratory illness. Most of those becoming ill did so during the period of December 5 through December 15. The epidemic curve for the outbreak was narrow.

During the time of the epidemic, approximately 50 per cent of the recruits on the base became ill. During the corresponding time, approximately 15 per cent of the permanent party personnel became ill. Symptoms included: sore throat, (75%), cough (70%),

headache (60%), fever (53%), aching muscles (46%), light-headedness (31%). The duration of illness was difficult to quantitate although in those not hospitalized the illness seemed to last only two or three days. Seventeen recruits had illness severe enough to require hospitalization. Half of those hospitalized had gastrointestinal symptoms in addition to respiratory symptoms. Specimens from 14 hospitalized recruits yielded isolates of Adenovirus type 7 from either the throat washings or stool specimens. In addition, nine recruits had diagnostic rises in antibody titers to Adenovirus. Nearly all of the hospitalized recruits had a florid exudative tonsillitis which was clinically indistinguishable from acute streptococcal pharyngitis. Throat cultures from each of the hospitalized recruits showed normal flora.

While the explosive nature of this outbreak suggested a common source exposure, no such common factor could be identified. Rather, it appears that this epidemic swept through a susceptible population in extraordinarily rapid fashion. Over the years, Adenovirus 7 infections have been a problem in military recruit populations. There is a new experimental Adenovirus 7 vaccine which has been used by the Army, apparently with good results. This vaccine probably does not have a real application for civilian use in that Adenovirus 7 disease infrequently occurs as an epidemic problem among civilians.

## Sale of Turtles Restricted

The New Jersey Public Health Council has passed the following regulation concerning the sale of turtles within the State. (Chapter III of the New Jersey State Sanitary Code, Regulation 7—Sale or distribution of live turtles.)

No live turtles shall be sold or in any way distributed or offered for sale or distribution within the State on or after July 1, 1972, except where the seller or distributor of the turtles shall warrant to the satisfaction of the State Department of Health that each shipment of turtles is free from salmonella contamination. The New Jersey State Commissioner of Health, in his discretion, may waive the requirements of this regulation for live turtles sold or distributed within this State for the purpose of research, other zoological purposes, or for food.

Basis of this action stemmed from studies which demonstrated that turtles are a frequent cause of salmonella infection in children. In a study done a year ago by the New Jersey State Health Department 124 families were interviewed who had a child ages 1 to 10 with a salmonella infection. A similar number of families were interviewed as a control group. Of the families in which a case of

salmonellosis occurred 22.6 per cent owned a pet turtle at the time of the infection. In contrast, in the control group where no salmonella infections occurred 5.6 per cent of the families owned turtles. Banning the sale of turtles in New Jersey ought to result in 10 to 15 per cent fewer salmonella infections per year, assuming people do not purchase turtles outside of New Jersey.

---

## New Physician Education Coordinator

Dr. Stanley S. Bergen, Jr., President of the College of Medicine and Dentistry of New Jersey, has announced the appointment of Dr. James A. Rogers of Paterson as coordinator of continuing physician education for the College. Dr. Rogers' initial assignment will be to establish the Office of Continuing Physician Education, a coordinating agency to unite more closely community hospitals, practicing physicians of all levels, and the health providers of the state with the College in continuing education.

The Advisory Council of the Office of Continuing Physician Education will include representatives of The Medical Society of New Jersey, Academy of Medicine of New Jersey, New Jersey Association of the Directors of Medical Education, New Jersey Association of Osteopathic Physicians and Surgeons, New Jersey Hospital Association, New Jersey Department of Health, New Jersey Department of Higher Education, and the College of Medicine and Dentistry of New Jersey.

Dr. Rogers and the Advisory Council will give high priority to patient care, the utilization of personnel and facilities, and the cost of health care which will benefit all the citizens of New Jersey. Dr. Bergen explained, "In view of the growing importance of continuing education to the health care of our citizens, it is a logical extension of our re-

sponsibility to the people of this state to join with the organizations on the Advisory Council in creating a viable continuing education program for New Jersey's physicians. Continuing education plays a vital role in the modern physician's ability to keep pace with technology and with the vast increase in medical knowledge needed to provide new and improved means of diagnosing and treating illness, in all of its aspects."

Dr. Bergen explained that in at least eleven states the medical societies are requiring their members to spend a designated number of hours in a three-year period in continuing education. The New Mexico State Board of Medical Examiners requires evidence of continuing education in accredited courses in order for physicians to retain their license to practice in that state.

Dr. Rogers was formerly director of continuing physician education for the New Jersey Regional Medical Program. He is the First Vice-President of The Medical Society of New Jersey and also is Chairman of its Committee on Medical Education.

Dr. Rogers is a practicing physician in Paterson and an attending physician in medicine at the Greater Paterson General Hospital. He is a Past President of the Passaic County Medical Society, and in 1972 he received the award of the Doctor of the Year from his county society. He served as a commissioner of the Board of Health of the City of Paterson from 1969 through 1971.

# PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.*

**ANESTHESIOLOGY**—Vida C. Baron, M.D., 43 Bronx River Road, #6-0, Yonkers, New York 10704. Howard 1969. Board eligible. Solo, group, or salaried. Available.

Farooq Qureshi, M.D., 1136 Vine Street, Liverpool, New York 13088. King Edward (Pakistan) 1967. Board eligible. Group, partnership, solo, teaching. Available.

**CARDIOLOGY**—Robert F. Marvin, M.D., 1118-C John Street, Charlottesville, Virginia 22903. Temple 1965. Board certified in internal medicine. Group, partnership, or hospital. Available.

**DERMATOLOGY**—Robert P. Feinstein, M.D., 9146 Springhill Lane, Greenbelt, Maryland 20770. NYU 1967. Board eligible. Group, partnership, or solo. Available July 1973.

**EMERGENCY ROOM**—Hervey S. Sicherman, M.D., 414 Hayes Circle, Fort Ord, California 93941. Part-time surgery or general. Available October 1972.

**INTERNAL MEDICINE**—Manuel M. Lin, M.D., 655 East 14th Street, New York 10009. University of Philippines 1965. Board eligible. Subspecialty, chest diseases. Institution, group, or partnership. Available.

Robert Weitzman, M.D., 216 Thelma Terrace, Linden 07036. CMDNJ 1966. Board eligible. Subspecialty, pulmonary disease. Group or partnership. Available October 1972.

**NEUROLOGY**—Richard N. Selby, M.D., 1705 Spaatz Drive, CAFB, Rantoul, Illinois 61886. Downstate Medical 1962. Board eligible. Group, partnership, institution, or solo. Available September 1972.

**OBSTETRICS/GYNECOLOGY**—Mahpara Razzi, M.D., 4247 Orion Park, Liverpool, New York 13088. Osmania 1961. Board eligible. Group, partnership, or hospital. Available.

M. T. Shahab, M.D., 1764 Yorktown Road, Cincinnati, Ohio 45237. Tehran 1962. Board eligible. Group or partnership. Available September 1972.

**OPHTHALMOLOGY**—Gilbert B. Sussman, M.D., 16 Hopkins Road, Liverpool, New York 13088. Downstate Medical Center 1967. Group, partnership, or association. Available.

Edward J. Martin, M.D., 1024 New Scotland Road, Albany, New York 12208. NYU 1966. Board eligible. Partnership or solo. Available.

**ORTHOPEDIC SURGERY**—Stephen Dineberg, M.D., 4412A, USAF Academy, Colorado Springs, Colorado 80900. Hahnemann 1965. Board eligible. Partnership or solo. Available.

Robert A. Bronfman, M.D., 8702 Pennsbury Place, Apt. 2, Richmond, Virginia 23229. CMDNJ 1966. Board eligible. Solo, partnership, group. Available July 1973.

**OTOLARYNGOLOGY**—Stephen R. Geller, M.D., 3807 Pecan Street, Portsmouth, Virginia 23703. Chicago 1966. Board eligible. Group or partnership. Available July 1973.

Gary L. Townsend, M.D., 117 Nebraska Street, Dyess AFB, Abilene, Texas 79607. Yale 1966. Board certified. Solo. Available July 1973.

**PATHOLOGY**—E. Clifford Heinmiller, M.D., 1124 Washburn Place West, Saginaw, Michigan 48602. Iowa 1943. Board certified. AP and CP. Subspecialty, computer science. Group for development of medical computer applications, medical records, diagnosis, etc. Available September 1972.

**PEDIATRICS**—Noel M. Wiederhorn, M.D., 42-10 Golden Street, Flushing, New York 11355. New York Medical College 1969. Board eligible. Group or partnership. Available.

Jung-shung Wang, M.D., 401 Armstrong Avenue, Jersey City 07305. Taiwan 1963. Board eligible. Group partnership, or solo. Available.

**SURGERY**—Vincent J. Begley, M.D., 25 River Road, C-26, Nutley 07110. New York Medical 1966. Board eligible. Solo or partnership. Available.

Sirous Arya, M.D., 79 Lincoln Boulevard, Kenmore, New York 14217. Tabriz (Iran) 1963. Board eligible. Group or partnership. Available.

**UROLOGY**—Bashiduddin N. Shaikh, Lockwood Clinic, 300 Bloor Street East, Toronto, Ontario, Canada. B. J. Medical College (India) 1961. Board eligible. Group, partnership, solo. Available.

Support the Society for  
Relief of Widows and Orphans

(P.O. Box 95, Belleville, N.J.)



---

# ANNOUNCEMENTS

---

## Course on Professional Liability in Medical and Dental Practice

On September 1 and 2, at the Essex House in New York City, the Practising Law Institute will offer an interdisciplinary course on professional liability. The program is designed for physicians, dentists, and attorneys and will cover all aspects of the subject. Registrants will be provided with an awareness of what constitutes or gives rise to professional liability and how it can be avoided. Request has been made to the AMA to survey the course for possible granting of postgraduate credit, and physicians who attend will be notified of the amount of credit allowed. The fee, which includes instructional materials, is \$100. Scholarship aid is available for interns and residents. For registration and further information, please contact Lee J. Dunn, Jr., Practising Law Institute, 1133 Avenue of the Americas, New York 10036.

## Special Cancer Detection Program

Sponsored by the Philadelphia Division of the American Cancer Society, the first of eight free postgraduate courses on "Cancer Detection in Office Practice" will begin September 6 at the American Oncologic Hospital, Philadelphia. The course lasts for five consecutive Wednesdays. Each session begins at 12:30 p.m. with luncheon and is completed at 4 p.m.

Emphasis is placed on individual, supervised instruction in proctosigmoidoscopy, head and neck examinations, including indirect laryngoscopy, and pelvic and breast examination. Special cancer detection technics, such as mammography and thermography are also discussed. The program includes patient demonstrations, a report on cancer research, and pertinent subjects in all major areas of cancer treatment.

The course is acceptable for category I, general practice credit. All interested practitioners

are eligible to attend. Additional information can be obtained by writing to the hospital or by telephoning 215-RA2-1900, extension 345.

Located in the Fox Chase section of Philadelphia, American Oncologic is the only hospital in Pennsylvania, and one of only nine in the country, devoted exclusively to the treatment of cancer and allied diseases.

## Gastroenterology Course in Bermuda

The American Society for Gastrointestinal Endoscopy announces a course for clinicians to be held in Bermuda, September 10 to 16. A program emphasizing new developments and the practical aspects of current methods of diagnosis and management of gastrointestinal diseases has been arranged. For details concerning the subjects to be covered and for information about accommodations in Bermuda and registration, please write to Vernon M. Smith, M.D. 301 St. Paul Place, Baltimore, Maryland 21202.

## Postgraduate Lectures in Surgery

The Department of Surgery of the New Jersey Medical School (CMDNJ) announces a "Distinguished Lecture Series" for 1972-1973. These programs are held monthly (Mondays) in the amphitheater on the 2nd floor at Martland Hospital (65 Bergen Street, Newark), beginning at 4 p.m. There is no charge, and guarded parking is available in parking area "M" at 12th and Bergen Streets. The first three scheduled are:

- |              |  |
|--------------|--|
| September 18 | Problems in Thromboembolism<br>Charles L. Eckert, M.D., Professor<br>of Surgery,<br>Albany Medical College                       |
| October 16   | Diagnosis and Treatment of Soft Part<br>Sarcomas<br>LaSalle D. Leffall, Jr., M.D.,<br>Professor of Surgery,<br>Howard University |
| November 6   | Splenectomy for Hematologic Disorder<br>Seymour I. Schwartz M.D., Professor<br>of Surgery,<br>Rochester School of Medicine       |

Additional lectures will be announced later. For further information, please contact Eric J. Lazaro, M.D., Professor of Surgery and Assistant Dean for Clinical Student Affairs, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

### **Rhinological Program in New Orleans**

From September 19 through 22, a special rhinological program will be offered by the American Rhinologic Society, in conjunction with their annual meeting to be held in New Orleans. The Louisiana State University School of Medicine is cosponsor of the program. The agenda includes material on respiratory physiology, on rhinomanometry, and on corrective nasal surgery. Also listed are presentations on breathing in space and under water. For more details, write to Dr. Gerard F. Joseph, 3622 Government Street, Baton Rouge, Louisiana 70806.

### **Courses in Medical Hypnosis**

Columbia University announces two courses in medical hypnosis under the direction of Herbert Spiegel, M.D. and A. A. Bridger, M.D. The first course will be Saturdays, 10 a.m. to 5 p.m., starting on September 30, 1972 and ending on November 18, 1972. This basic course will include lectures, practice sessions, movies, and slide seminars and will emphasize the adjunctive use of hypnosis in clinical medicine. Tuition fee for this basic course is \$175. The second program, on Saturdays from January 6 through January 27, 1973, will be for professional persons who have taken the basic course or its equivalent. This course carries a fee of \$100. For more information, write to Melvin D. Yahr, M.D., Associate Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 10032. Identify the basic course as PM 4 and the advanced course as PM 5.

### **Course in Pediatric Allergy**

An all-day program in pediatric allergy is scheduled for October 5 at the Helene Fuld Hospital in Trenton, and a repeat on October

25 at the Holy Name Hospital in Teaneck. The first paper is set for 10 a.m. and the last presentation will begin at 2:30 p.m. A general round table will follow the formal presentations. This is sponsored by the New Jersey Allergy Society. The only cost will be a \$10 registration fee. If interested, please send your check, made out to the New Jersey Allergy Society, to Michael S. Mattikow, M.D., at 330 Ratzel Road, Wayne, New Jersey 07470.

### **Peripheral Arterial Disease**

Temple University announces a two-day symposium on October 27 and 28 on peripheral arterial disease: current concepts of diagnosis, medical and surgical treatment, and prosthetic applications. This will be at the University's Conference Center, 9230 Germantown Avenue, in Philadelphia. Registration is limited. Tuition fee is \$100. For more details, write to the Department of Rehabilitation Medicine, Temple University Health Sciences Center, 3400 North Broad Street, Philadelphia 19140.

### **Medical History Conference**

On Saturday, October 28, the second annual conference of the Society of New Jersey Medical Historians will be held at the New Brunswick campus of Rutgers University. The meeting will open at 9 a.m. and close at 4 p.m. Interested in attending or in contributing? Write to Professor David Cowen of the Department of History at Rutgers University, New Brunswick, New Jersey 08900.

### **Continued Education Seminar**

February 25, 1973 through March 3 are dates for the session of the American Society of Contemporary Medicine and Surgery. This meeting will be held at the Fountainbleu in Miami Beach. These courses are approved for continuing education credit by the AMA. Michael DeBakey, M.D., President of the Society will give the keynote address. The Bobst lecture on cancer will be included in this program. For more details, write to Miss Virginia Kendall, Room 1629, 30 North Michigan Avenue, Chicago 60602.

---

# LETTERS TO THE JOURNAL

---

## Residential Placement— Not Always Detrimental

April 17, 1972

Dear Sir:

A committee of doctors, recognized for their experience in the field of mental retardation, has recently published (this *Journal*, 69:361, April 1972) a statement revealing its views, conclusions, and recommendations concerning "institutional placement for the mentally retarded."

The making of a decision as to whether to institutionalize a retarded child is difficult for the parents at any time. I feel compelled to comment upon the Committee's "policy statement" in order to present a somewhat less rigid, perhaps more helpful, view than appears to be contained in that document, and possibly to facilitate arriving at a decision.

The Committee recommends, in its concluding statement, that "residential placement for the mentally retarded infant or child be held off as long as possible." It is with such an unqualified, categorical declaration that I disagree, notwithstanding the Committee's understatement that "it is recognized that there are some circumstances under which early residential care is timely and essential."

The Committee writes that "doctors are often too quick to recommend institutional placement for the mentally retarded." I have no evidence to dispute that. On the other hand, at least as equally often, doctors may be too slow to do so.

The statement is made that "early recommendation (for residential placement) in many instances is detrimental to the infant or child

and may lead to a guilt complex on the part of the parents." The word "many" is a relative term, but if this assessment is significantly true, I must have overlooked its extent during my 30 years as medical director at a State facility for the mentally retarded. I do not hesitate to say, however, that in my experience, early recommendation for residential placement has not, in the vast majority of cases, been detrimental to the child, and may also have prevented, or led to the release of parents from the fetters of a guilt complex which might have, for too long, compelled them to hold off placement "as long as possible."

I am certain that no one would argue against the Committee's belief that "there are valid reasons for home care of the young retarded person," but I would argue that there are equally valid reasons, too, for their institutionalization.

In the interests of the mentally retarded, I would submit that the potential saving of "enormous sums of money by home care rather than traditional residential care" is, *per se*, a totally unworthy and unbecoming reason for recommending home care.

The report provides two additional reasons for recommending home care. First, that "from the parents' viewpoint, home care is preferable." I agree that this is true in many cases. But the parents' viewpoint is frequently emotional, infrequently objective, and consequently not infrequently irrational. Second, that "often initially there is an inaccurate assessment of the degree of mental retardation," but more often than not, there is, at least by the parent, a greater erroneous overestimation of the child's mental capacity and potential rather than a miscalculated underestimation of them.

What I mean to say in the above critique is that I believe no statement can properly generalize the disposition and management of all mild, moderate, and profoundly retarded children.



The Committee's singling out and citing a victim of Down's syndrome which, within its own confines, is markedly varied in its severity serves little purpose as a justification for lumping together the disposition of all the numerous other syndromes and idiopathic cases of mental retardation.

I join the Committee in decrying "indiscriminate residential placement." And, although our institution is devoted mainly to the severely retarded, I propose that each case of mental retardation calls for individual consideration. Many factors, including the parents, siblings, residence, educability, trainability, severity and classification of the retardation, and worthiness of the institution, require attention.

Finally, I agree, of course, as the Committee ultimately concludes, that "the final decision (should be) made by the parents with professional guidance."

(signed) Jules Cooper, M.D.

### In Defense of Darvon®

April 20, 1972

Dear Mr. Editor:

In a recent *New England Journal of Medicine*, D. B. Moertel, *et al.*, published an article entitled "A Comparative Evaluation of Marketed Analgesic Drugs."

The authors administered in a randomized, double-blind manner nine oral analgesic drugs and a placebo. They concluded that aspirin (650 mg.) was superior to the other drugs tested. They also concluded that "the therapeutic credentials of . . . propoxyphene . . . must be classified as very equivocal." Propoxyphene is Darvon®.

Aspirin is an effective oral analgesic. It is sufficient for the pain relief needed in many situations. But it is also well established that Darvon® is an effective analgesic. This is substantiated by recent studies conducted in connection with the introduction of Darvon-

N<sup>TM</sup> (propoxyphene napsylate, Lilly) and Darvon-N<sup>TM</sup> with A.S.A.® (propoxyphene napsylate with aspirin, Lilly), as well as by many studies conducted at the time of the introduction of propoxyphene hydrochloride. Studies reported in the July 1971 *Toxicology and Applied Pharmacology* again affirmed the effectiveness of Darvon®. Also, the NAS/NRC expert panel which reviewed Darvon® for the Drug Efficacy Study of the Food and Drug Administration concluded that Darvon® is an effective drug.

The physician often finds himself with the patient who has not been sufficiently relieved by aspirin and needs something more. Prior to Darvon® this was frequently codeine, a drug most clinicians would concede is a potent analgesic. (Incidentally, in one method Dr. Moertel used to analyze his results, 65 mg. of propoxyphene ranked higher than 65 mg. of codeine.)

The advantage of Darvon® (propoxyphene hydrochloride, Lilly) over codeine is its lower incidence of untoward reactions. In a comparative study of these two compounds, Darvon® had a side-effect incidence of 0.8 per cent as compared with 3.4 per cent for codeine.\*

The Moertel study admittedly did not consider the value of combinations of two or more drugs that provide analgesia. Not all compounds produce their analgesic effect by the same mechanism. For example, aspirin has a significant peripheral activity for pain relief as well as an anti-inflammatory action, whereas the action of propoxyphene is primarily central. The combination, quite obviously then, attacks pain by two mechanisms. For these reasons, we have combined these analgesics in Pulvules® Darvon® Compound (propoxyphene hydrochloride, aspirin, phenacetin, and caffeine, Lilly) and Darvon® with A.S.A.® (propoxyphene hydrochloride and aspirin, Lilly). The NAS/NRC panel commented that "the combination of Darvon®

\* Borda, I. T., Slone, D., and Jick, H.: *JAMA*, 205:645 (1968)

with an antipyretic-analgesic of the aspirin type results in analgesia superior to that achieved by either drug administered alone." In fifteen years, Darvon® products have won remarkable acceptance by many thousands of physicians and millions of patients. This success has been well deserved. It is based on satisfactory relief of mild to moderate pain and on a high degree of safety.

(signed) Eli Lilly and Company

### Blue Cross Blues

May 25, 1972

To the Editor:

Many doctors in New Jersey, like myself, joined the group contract with Hospital Plan and Medical-Surgical Plan of New Jersey at its inception and have continued in the belief that we thus have coverage for ourselves and our dependents when illness occurs. But now I wonder whether we do have the protection we have been paying for.

Recently I was seriously ill for an extended period and so notified my attending doctors and the hospital to submit claims to Medicare-B and the New Jersey Plans. Then I received a form letter from Medical-Surgical Plan stating that they cannot find any record of my enrollment and so they would not make payment to the doctors. This form had spaces

wherein I was to enter various identifying numbers, if I think I'm included in the County Medical Society's group contract with the Plan.

I promptly entered the identifying numbers in this form letter and mailed it back to the Plan. I also telephoned the Executive Officer of my county society to verify that I was credited with membership in the group contract and to have him phone the Plan re its mishandling of my claim. Then I phoned the hospital wherein I had been treated for some ten weeks and ascertained the Hospital Plan of New Jersey and Medicare-A had paid it their full share of my hospital expense, thus proving that the group contract, including my coverage, had been received and properly processed by Hospital Plan and Medicare-A. But the anxiety remains as to the predicament my wife would be in had I died during that illness and were she confronted by this form letter from Medical-Surgical Plan, not knowing whom to call to obtain help in righting the wrong imposed by Medical-Surgical Plan. Undoubtedly, she would just pay out of her pocket.

Doesn't it seem to you, and to other members of our Society that an official inquiry, or investigation, is called for to be certain that correction is obtained?

(signed) Albert G. Hulett, M.D.

---

## OBITUARIES

---

### Dr. Kasimier J. Bolanowski

On May 17, 1972, death came to Kasimier J. Bolanowski, M.D., at the age of 63. He was a 1935 alumnus of the Medical School at Harvard, and was a general surgeon on the staffs of both Alexian Brothers and Saint Elizabeth Hospitals in Elizabeth. Dr. Bolanowski was a Fellow of the New Jersey Academy of Medicine, and an active member of our Union County component society.

### Dr. L. Roberto Carmona

At the age of 75, death came to L. Roberto Carmona, M.D., on April 26, 1972. Born in Puerto Rico in 1897, he was a 1923 graduate of the Medical School at Boston University. He came to Ocean County after completing internship and was active in civic affairs in that area. He was school physician for Little Egg Harbor Township, and was on the Board of Directors of the First National Bank of Tuckerton. He was affiliated with the Paul Kimball Hospital in Lakewood. He was Treasurer of our Ocean County Medical Society in 1940, Secretary in 1945, and President of that

component society in 1947. Last year, after almost half a century of family practice, he retired to Hollywood, Florida.

#### **Dr. Alexander S. Chiger**

Alexander S. Chiger, M.D., died on April 17, 1972 at the grand age of 88. A graduate of New York Medical College in 1910, he was a family doctor of the old school who, before his retirement, was on the staff of the Irvington General Hospital. He was a member of our Essex County Medical Society. In 1960, Dr. Chiger was a laureate of our Golden Merit Award.

#### **Dr. Edward Dana**

Edward Dana, M.D., born in 1913, died on May 4, 1972, at the age of 59. His medical degree was awarded at Albany in 1940. He was an orthopedic surgeon on the staff of the Hackensack Hospital, and also was much concerned with traumatic surgery. Dr. Dana practiced in Upper Saddle River, and was a member of our Bergen County Medical Society.

#### **Dr. Ronalda DeAndrade**

At the untimely age of 42, death came on May 7, 1972, to Ronalda DeAndrade, M.D. Board certified in pediatrics, he practiced his specialty in Wyckoff. He was a 1954 alumnus of the Medical School at the University of Brazil. Dr. DeAndrade was active in our Bergen County Medical Society.

#### **Dr. Augustus Gibson**

Born in 1908, Augustus Gibson, M.D., died on June 1, 1972. He received his M.D. degree at Columbia University's College of Physicians and Surgeons in 1934. Much of his work had been in the field of hematology and pharmacology. Dr. Gibson for many years did research at the Schering Corporation. He was also active in the American Rheumatism Association and was a member of the International Society of Hematology. At the time of his death, he was living in Stockton, New Jersey.

#### **Dr. Alfred S. Goldsmith**

An attending orthopedic surgeon at North Hudson Hospital in Weehawken and at St. Mary's Hospital in Hoboken, Alfred S. Goldsmith, M.D., died on December 5, 1971. He was graduated in 1933 from the Medical School of the University of Iowa. He was a Fellow of both the American College of Surgeons and the New Jersey Academy of Medicine. Dr. Goldsmith was 62 at the time of his death.

#### **Dr. Harry L. Golish**

On June 18, 1972, death came to Harry L. Golish, M.D., at the age of 66. He was a member of our Passaic County component society. His first field of medical interest was allergy, but subsequently he qualified for practice in orthopedic surgery. He was a Fellow of the American Geriatric Society. Dr. Golish was on the staffs of the Passaic Beth Israel, the Barnert Memorial, and the Paterson General Hospitals.

#### **Dr. Daniel G. Jarvis**

Daniel G. Jarvis, M.D., an Assistant Medical Director of the Mutual Benefit Life Insurance Company, died on May 5, 1972. He had been born in 1912 and received his M.D. at Western Reserve in 1938. He was board certified in obstetrics and gynecology and for many years was on the staffs of St. Michael's Hospital in Newark and of the East Orange General. Dr. Jarvis had retired from active practice in 1968. He was a Fellow of the American College of Surgeons, the American College of Obstetrics and Gynecology, and the Academy of Medicine of New Jersey.

#### **Dr. Clifford H. Kanengiser**

A 1938 alumnus of the Medical School at Syracuse University, Clifford H. Kanengiser, M.D., died on May 20, 1972, at the age of 58. He was an associate attending general surgeon at the Christ Hospital in Jersey City. Dr. Kanengiser was a Fellow of the International College of Surgeons.



### **Dr. John E. Kiley**

At the age of 84, John E. Kiley, M.D., died on June 4, 1972. Dr. Kiley was a well-known Essex County dermatologist who served Mountain-side Hospital in Montclair and the Essex County Sanatorium in Verona. During World War I he was a captain in the medical corps of the Army. Dr. Kiley was a 1913 graduate of the Chicago Medical School.

### **Dr. Louis J. Levinson**

Word has been received from Florida of the death there, on July 9, 1971, of Louis J. Levinson, M.D., at the age of 70. A native of Brooklyn, Dr. Levinson served his internship at the Newark Beth Israel Medical Center. He was a pioneer in the development of radiotherapy for malignancies and was a diplomate in radiology. For many years, he directed the radiotherapy service at Beth Israel. He was also affiliated with the Morristown Memorial Hospital. He had several tours of duty on the Board of Managers of the American Cancer Society. Dr. Levinson was a 1928 alumnus of the Medical School at the University of Maryland. In 1966, he retired and moved to Florida. He was an Emeritus Member from our Essex County component.

### **Dr. John G. Merselis**

A 1923 graduate of Johns Hopkins, John G. Merselis, M.D., died on May 19, 1972 at the age of 75. He was a general practitioner with a special interest in otolaryngology and was affiliated with the Orange Hospital Center. Dr. Merselis was active in the affairs of our Essex County Medical Society.

### **Dr. Vincent Pellegrini**

Vincent Pellegrini, M.D., had two specialties. He was well known for his work in pediatrics and had been associated in that department at the Hackensack Hospital. He had been an instructor in that specialty at his alma mater, the New York Medical College, from which he had received his M.D. in 1936. He was also active in occupational and industrial medicine, and a member of the Industrial Medical Association. Dr. Pellegrini was a

member of our Bergen County Medical Society. Born in 1910, he died on April 26, 1972 at the age of 62.

### **Dr. Louis J. Radest**

One of Passaic County's better-known family physicians, Louis J. Radest, M.D., died at the age of 71, on May 22, 1972. He was a graduate of Loyola University School of Medicine, class of 1926. Dr. Radest was a member of our Passaic County Medical Society.

### **Dr. Joseph A. Smith**

Formerly superintendent of the State tuberculosis sanatorium at Glen Gardner, Joseph A. Smith, M.D., died on April 4, 1972. Born in 1905, he earned his M.D. at Long Island Medical College in 1935. He had had a tour of duty as President of the New Jersey College of Chest Physicians from 1951 to 1953. He was a consultant in chest disease at All Soul's Hospital in Morristown and at the Hunterdon Medical Center in Flemington. Dr. Smith was a Fellow of the American College of Physicians, the American College of Chest Physicians, and the American Geriatric Society. He had retired from active practice in 1967.

### **Dr. David F. R. Stuart**

Word has just come from Sag Harbor, New York, of the death there, on October 17, 1971, of David F. R. Stuart, M.D. Born in 1901, Dr. Stuart was a Temple graduate in the class of 1928. He was a cardiologist and a member of our Morris County Medical Society. He had retired in 1967 and moved to New York State.

### **Dr. Victor Wasilewski**

A well-known Passaic County anesthesiologist, Victor W. Wasilewski, M.D., died on April 25, 1972 at the age of 60. He was an alumnus of the Medical School at Vilno in Poland, and was on the staff of the Beth Israel Hospital in Passaic. Before coming to Passaic County, he had done general practice in Ocean County. He was a member of the American Society of Anesthesiologists.

---

# BOOK REVIEWS

---

**Compensation in Psychiatric Disability and Rehabilitation.** Edited by Jack Leedy, M.D. Springfield, Illinois, Thomas, 1971. Pp. 361. (Price not given)

We live in a disability-conscious world. If a person can prove that he has a disability, all sorts of good things might happen to him—excuse from hard or dangerous work, sympathy of neighbors, no need to get up early in the morning, and a small but steady income. With certain types of disability objective evidence can be produced, often reducible to numbers, such as an error of refraction or the degree of motion in a joint. Psychiatric disability presents an especially difficult problem, because one can have a severely disabling emotional disorder with no objective evidence at all. The physician is further confused by the fact that he is expected to be patient-oriented, and it is difficult to get the average doctor to worry about the effect on society, in the abstract, of too generous a policy.

We have here a solid book by seventeen different contributors which reviews as many facets of this problem. Several chapters do suggest concrete, if not always objective criteria. Dr. Leonard Abramson (a New Jersey psychologist) describes the role of the psychologist in psychiatric rehabilitation. Allen Ene-low (a professor of psychiatry at Michigan) discusses malingering as a diagnostic problem. Several authors review the varied occupational risk factors. Dr. Edward Dangrove (a New Jersey psychiatrist) speaks of sexual disorders in post-traumatic states. Several of the sections deal with rehabilitation techniques, but the bulk of the material concerns compensation. The psychological factors in determining compensation are well reviewed.

All in all, this volume is unique in that it lights up the factors that have to be weighed in making decision about disability in emotional disorders.

HENRY A. DAVIDSON, M.D.

**Cellular Pathology.** Rudolf Virchow (Translated by Frank Chance). New York, Dover Press, 1971. Pp. 554. Illustrated. (Soft Back—\$5)

Here is the original English translation of this famous book, really a series of lectures, dated 1860. The talks were given in 1858 at the Pathological Institute in Berlin where 700 to 800 bodies were examined annually. Subjects covered include Cells and the Cellular Theory, Physiological Tissues (by which he means organs), Pathological Tissues, Nutrition and Circulation. Blood and Lymph (and, here is first used and defined the word "Leukemia"), Pyemia and Leucocytosis, Metastatic Dyscrasias, Pigmentary Elements in the Blood, Spinal Cord and Brain, Fatty Metamorphosis, Amyloid Degeneration, Inflammation, and Form and Nature of Pathological New-Formations (Tumors are included here).

This is a fascinating book and should be read by all pathologists and all others interested in the history and development of modern medicine. Virchow stated the thesis that human disease was related to cell

changes, hence the title "Cellular Pathology." With this in mind, I quote from the first paragraph, Chapter I, of the just-received *Basic Pathology* by Robbins and Angell (Saunders, 1971): "Begging the forgiveness of the clergy and the poets, we may begin this consideration of pathology with the observation that man is ultimately a complex aggregation of very clever cells. Health implies therefore that cells are healthy. Conversely, when a significant number of cells become deranged, disease exists. It is the purpose of this chapter to probe into the cell in health and disease." Imagine this 111 years later! Fellow pathologists and medical historians read this book by Virchow; you will find something of interest on almost every page.

There is an introductory essay by Dr. L. J. Rather, Professor of Pathology at Stanford. It is well written and briefly summarizes the various theories of disease up to the time of Virchow. Thus the scene is developed so that the meaning of these lectures given in 1858 can be related to knowledge at that time.

Hugh F. Luddecke, M.D.

**Lasers in Medicine.** Leon Goldman, M.D. and R. James Rockwell, Jr. New York, Gordon Breach Scientific Publishers, 1971. Pp. 385. Illustrations 135. Charts 105.

The laser has caused considerable excitement as one of the latest "wonder tools" of the scientific world and much hope has been stimulated (along with some misconceptions) as to what this awesome phenomenon has to offer the physician. This is the first comprehensive text on the subject written primarily with the practitioner in mind. The authors do a good job of explaining the complex background of the discovery and its development with full attention (possibly too much) to the mathematical and physical formulas. Excellent discussion is provided on the types of available equipment and their specific applications. The authors deserve credit for their honest views on the limitation of the laser in clinical practice and wisely call attention to the need for a system of safety controls and regulations before the community gets too deeply involved in the mysterious, powerful tool that the laser represents. All in all, this is a good book produced by a distinguished large university group who recognize the need to get the subject integrated into a single textbook. Illustrations are profuse and easy to grasp. The index is excellent.

Sydney B. Lewis, M.D.

**Mental Health Program Report, Number 5.** Edited by Julius Segal, Ph.D. National Institute of Mental Health. Washington, D. C., U. S. Government Printing Office, 1972. Pp. 388. (Softback—\$1.75)

The National Institute of Mental Health is concerned with supplying leadership in psychiatric research and, in the long run, with improving the quantity and quality of mental health services to all the people. The current volume offers program reports on the biochemistry of schizophrenia, community mental health centers, biofeedback in the control of autonomic functions, mental competency to stand trial, the development of intelligence in babies, the long-term effects of L.S.D., programs for disadvantaged children, and many related topics. Thought-stimulating comments salt each chapter. The heterogeneity of the volume makes it an interesting bedside reader, a text into which one can dip in small doses. As a whole, it is a panorama of the directions being taken by our pioneer national agency in the field of mental health.

Herbert S. Boehm, M.D.



**Pediatric Therapy**, 4th Edition. Harry C. Shirkey, Editor, St. Louis, Mosby, 1971. Pp. 1221. Illustrated. (\$34.50)

This multi-authored book was compiled by almost one hundred authors. First published in 1964, this 1971 volume now represents a fourth edition and, as the editor states at the beginning of the book, therapy, of course, is a "rapidly changing field." The book has a two-fold purpose: to present concise textual matter pertaining to a particular condition and to offer detailed orientation to treatment. The non-therapy matter contains many "pearls" peculiar to the diseases under discussion, diagnostically. Could the title of the book be a misnomer? Dr. Shirkey has one advantage over other authors with a book of this type, in that he started his career as a pharmacist. Technically the book's contents are presented in an orderly and interesting fashion. Besides medical therapy, sections dealing with pediatric surgery, anesthesia, radiation therapy, and so on are included. The sections on poisons and the table of drugs are particularly good. Notably absent, however, is a chapter dealing with pediatric emergencies *per se*. Weaknesses in a book of this type include redundancy of matter (the chapter dealing with fundamental drug therapy, for instance) and discrepancy of opinion (separate chapters dealing with Beta hemolytic streptococcus and scarlet fever). The other obvious weakness is that a book of this type becomes outmoded quickly.

This text is intended for all practitioners and allied paramedical personnel who treat children. I would like to see the section on systemic antimicrobial therapy circulated for review by all physicians and drug detailmen.

Frank C. Vanore, M.D.

**A Civilian Doctor in Vietnam**. Fred Gloeckner, M.D. Philadelphia, Winchell, 1972. Pp. 123. Illustrated. (\$5)

This book documents the daily horrors and anguish with which one is confronted in a hospital in Vietnam. Having done a similar stint in the Mekong Delta myself, I can appreciate the care which one must exercise in treating wounded and sick patients under unbelievable circumstances. Dr. Gloeckner kept a diary in which he reported the daily bombings, machine gunning, shrapnel, and napalm burns which he had to treat while under fire himself.

He explains his life among a people who have never known peace. He philosophizes on the inhumane war and the political impact which the American government has had through its commitment to that country.

The book reads easily for one, like myself, who has ministered to the sick and wounded of both the South and the North Vietnamese with makeshift drugs and appliances. I don't think it would have the same response to an "outsider." The book can be read in one evening. Try it—you may like it.

S. William Kalb, M.D.

**American Medicine in Crisis**. Edward P. Luongo, M.D. New York, Philosophical Library, 1971. Pp. 194. (\$9.95)

In a sense, things are always "in crisis." However, the doomsday phrase seems especially appropriate these days. (As one wit put it—things being what they are, paranoia is the only sensible state of mind.) Professor Luongo here re-examine the basic philosophy of medical practice. He is interested in

stressing the social as well as the physiologic causes of disease. He is aware of the trouble produced by modern labeling of disease entities. He develops an interesting concept of the physician as, in a sense, an antagonist of nature. And he highlights the importance of the physician developing his communicative antennae to the point of really sensing how the patient feels about his disability. In spots, the text is heavy reading but we would all be better off for letting this material start a train of thought in ourselves.

Abraham Lelf, M.D.

**Current Concepts in Dyslexia**. Edited by Jack Hartstein, M.D. St. Louis, Mosby, 1971. Pp. 212. Illustrated. (Price not stated)

This is a well-written book. The presentation is logical and sequential. The interdisciplinary approach is stressed and carefully outlined. The editor has explained the need for a complete ophthalmologic evaluation in the diagnosis and treatment of the dyslexic child.

The role of the reading teacher and the education for children with reading disorders is presented clearly and practically.

The welding together of ophthalmologist, neurologist, reading teacher, audiologist, ear, nose, and throat man, psychologist, and the educational system in the management of the dyslexic child is superbly well done and is a welcome change to those involved with these children.

It is my view that the chapter on drug usage may be a bit too conservative. It is, however, a thoughtful and well-documented presentation.

This book is a "must" for those working with dyslexic children, since nowhere else do I know of such a well organized and direct approach as found here.

Miles E. Drake, M.D.

**A Primer for Electrocardiography**. (Sixth Edition). George E. Burch, M.D. and Travis Winsor, M.D. Philadelphia, Lea and Febiger, 1972. Pp. 292. Illustrations 287. (\$7.75)

This standard textbook has been published since 1945, through many printings. It is now in eight languages. The authors adhere to basic principles and intentionally avoid the new, the unproved, and the controversial. As a primer for medical students, externs, and house officers, the book is adequate but not ideal. It is marred by some major exclusions (no discussion of the important concept of the hemiblocks, pacemakers are not mentioned, illustrations are drawn, no actual EKG's are shown), some questionable retentions (16 pages devoted to ventricular gradient now viewed as questionable by many experts), and some outmoded terminology ("nodal" instead of junctional, "posterior" instead of inferior).

This new edition is virtually unchanged from the 1966 product and very similar to the competition (Libman and Massie).

The book is useful to the reader who wants to learn the basics of cardiac electrophysiology with the caution that it is neither complete nor absolutely authoritative. However, to my knowledge a better one has not been written.

Norman Riegel, M.D.



**Private practices** — \$40,000 minimum collections guaranteed first year, payable monthly. Not a loan. Need general practitioners, internists, OB/GYNs, anesthesiologists, and orthopedists in many states. Practices available for 1972-73-74. Not an employment agency. No cost to physician to investigate practice. Write or call Sanford Smith, Director of Physician Planning, Hospital Affiliates, Incorporated, P. O. Box 9836, Houston, Texas 77015. 713/453-6324.

## **THE MEDICAL SOCIETY OF NEW JERSEY**

### **Professional Liability Insurance Program**

#### **Society Endorsed Coverages—**

- Professional Liability for  
Individuals  
Partnerships and Professional Corporations  
Employed Nurses, Technicians or Aides
- Professional Premises
- Excess (Umbrella) Liability—Limits up to \$5 Million

#### **Management of Loss Control Program—**

- Claims Peer Review
- Prompt Advice Regarding Potential or Actual Claims
- Defense by Highly Skilled and Experienced Counsel
- Investigation by Specialists in Malpractice

## **JOSEPH A. BRITTON AGENCY**

**15 South Munn Ave., East Orange, N.J. 07018**

**(201) • 673-3060**

## GENERAL PRACTITIONER OR INTERNIST

Wanted for the

Medical-Surgical Section of Trenton Psychiatric Hospital. Salary range for General Practitioners \$20,731 to \$26,953; for Internists \$22,856 to \$29,714, depending on qualifications. Excellent fringe benefits. Live and work in historic Trenton. For further information, write M. H. Weinberg, M.D., Medical Director, Trenton Psychiatric Hospital, Trenton, N.J. 08625.

## INTERNS NEEDED

General Practice for 87-bed fully accredited community hospital in Southern New Jersey. E.C.F.M.G. Certificate — \$17,000—Blue Cross/Blue Shield—Midway Philadelphia — Atlantic City 30 minutes away — Opening immediately. Send full particulars to Box No. 21, c/o THE JOURNAL.

## INTERNISTS and FAMILY PHYSICIANS

Internists and family physicians badly needed in Atlanta suburb near third busiest airport in world. New offices available adjacent to new 385-bed South Fulton Community Hospital.

Mr. Jim Henderson

Please contact: Lee-Dixon Realty, Inc.

5075 Old National Highway

Atlanta, Georgia 30349

Phone: (404) 762-8175

## MEDICAL-DENTAL GROUP

It is the desire of a Dentist to bring a Medical-Dental group together, and acquire a building, thereby turning it into a Medical-Dental Professional Building as a corporation for its participants.

The building is located in Central New Jersey, a rapidly growing, middle-class suburban area, on the border of a large township (pop. 40,000) and a borough (pop. 15,000), which are in the fastest growing section of this suburbia (the township has a growth rate of 50% each year). This also is a business section with three big shopping centers nearby.

Neither the township nor the borough has a pediatrician or an Ear and Nose specialist. There is only one ophthalmologist between the two, and the borough does not have an obstetrician. There is still room for a general surgeon.

Anyone who wishes to open a new office or relocate a practice, please write to Box No. 22, c/o THE JOURNAL.

## NEW JERSEY

FULL TIME PART TIME  
EMERGENCY ROOM  
VARIED SHIFTS AVAILABLE  
NEW JERSEY LICENSE REQUIRED

APPLY: R. J. Matthews, Personnel Director, Point Pleasant Hospital, Osborn Avenue and River Front, Pt. Pleasant, N.J. 08742  
Phone (201) 892-1100

## PART-TIME PHYSICIANS

In Ophthalmology, Orthopedics and Urology. Excellent opportunity for retiring Physicians and recent residency graduates. Write:

Chief, Outpatient Clinic

Veterans Administration

20 Washington Place

Newark, N.J. 07102

Phone: (201) 645-3430

**PHYSICIANS WANTED:** Psychiatrist—Immediate openings to work on Psychiatric Services. Also openings in community mental health clinics in need of expansion. Jersey Shore Area. Excellent personnel programs and benefits. May have part time practice. State License required. Salary to \$29,714.00 depending on qualifications. Send resume in confidence to Michael R. Simon, M.D., Medical Director, Marlboro Psychiatric Hospital, Marlboro, New Jersey. Telephone: 201-946-8100.

## WANTED

Partner in established Family Practice, suburban New Jersey. Will also participate in development, administration and teaching of Family Practice Residency Program at 550-bed hospital. Write Box No. 20, c/o THE JOURNAL.

# CLASSIFIED ADVERTISEMENTS

**GENERAL PRACTITIONER WANTED**—To practice afternoons and assume hospital work. No investment, immediate income. Bayshore town in Monmouth County. Write Box No. 15, c/o THE JOURNAL.

**ASSOCIATE WANTED**—In Urology. Beautiful suburban area. Not far from Philadelphia. Excellent opportunity for the most suitable candidate. Position available immediately. Dr. Howard Mazer, (609) 428-0299. Call evenings.

**UROLOGIST WANTED**—Board certified or eligible to join 2-man certified incorporated group in North Central New Jersey, 15 minutes from New York City. Leading to full partnership in 3 to 4 years. Write Box No. 14, c/o THE JOURNAL.

**OPHTHALMOLOGY PRACTICE AVAILABLE** —Retiring. One story office building. Lucrative solo practice. No strings. Flexible arrangements. Great suburban opportunity. Samuel H. Stein, M.D., P. O. Box 655, Willingboro, New Jersey 08046.

**AVAILABLE**—Active medical office with or without combined residence for general practice in Jersey City. Excellent opportunity due to recent death. Write Box No. 19, c/o THE JOURNAL.

**FOR SALE**—Skull for teaching purpose. Best offer. Call (201) 796-6999.

**HOUSE FOR SALE**—Sussex County, \$31,900, lakefront, all year-summer, country like, beautiful grounds, 3 bedrooms, eat-in kitchen, modern bath, garage. Call (201) 796-6999.

**FOR SALE**—Chatam, New Jersey. Internist leaving established 12-year old successful practice for health reasons. Ideally situated, 4 nearby suburban hospitals. Air-conditioned, 4 bedroom home, swimming pool, 6 room office combination with laboratory. Large parking area. Extensive records. Corner property, 2-car garage with electric doors. May purchase home-office combination or practice separately. R. F. Zuch, M.D., 635-500 or 377-8133.

**FOR SALE**—Trenton, New Jersey. Home-office, semi-detached brick house near Mercer Hospital in professional area. Lot 50' x 300', ample parking, 3-car block garage. Prominent physician occupies home and office, 32 years. Central air conditioning, oil heat, 4 zones. Office—waiting room, consultation room, 2 examining rooms, 2 tile lavatories, large laboratory, instrument room, large closets. Over office, 5-room modern apartment. Home—8 rooms, 3 baths, ample closets. Home can be easily converted into two units. Will finance. Write Box No. 10, c/o THE JOURNAL.

**MEDICAL OFFICES AVAILABLE**—Manville, New Jersey. Excellent, convenient, attractive and established location. Ground floor professional building. Shortage of physicians and dentists. Great suburban opportunity, 35 miles to New York. Call (201) 725-0272.

**SPACE AVAILABLE**—Woodbridge, New Jersey, Highway 35, Amboy Avenue, 700 to 2000 square feet in modern one-story medical speciality building. Central heating and air-conditioning, ample off-street parking. Call (201) 634-4225.

**Information for Advertisers—RATES:—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifth of preceding month.

**PERSONNEL  
REQUIREMENTS  
SEE  
705 and 706**

## **COLLECTIONS HENRY-LESLIE ASSOCIATES**

**"BONDED"**  
P.O. BOX A  
CRANBURY, N. J. 08512  
(609) 395-1760

—  
P.O. BOX 905  
TOMS RIVER, N.J. 08753  
(201) 244-2502

*Professional Services for the Health Professions*  
**NO CHARGE UNLESS WE COLLECT**

## **DOCTOR'S OFFICE & RESIDENCE**

Ranch home consists of 3 king sized bedrooms, 12x17; formal dining room 14x24; living room with fireplace; family room with wet bar and 10x15 sun porch. Lower level consists of 13x20 waiting room; 3 treatment rooms, bath and doctor's office with separate entrance. Centrally air-conditioned on both upper & lower levels. Centrally located minutes from Morristown Memorial & All Souls Hospitals.

**J. ROGERS INC.**

**BROKERS, 18 ELM STREET, NORRISTOWN 540-0300**



TEMPLE UNIVERSITY HEALTH SCIENCES CENTER presents the 16th Annual Postgraduate Course, Recent Advances in Medicine, on 8 consecutive Wednesday's from October 18 to December 6, 1972 from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand Rounds, Clinics, Case Discussions, Office Procedures, Lectures, Panel Discussions, Luncheon with the Experts, all with audience participation.

Faculty: Members of the Department of Medicine and other selected Departments of Temple University Health Sciences Center.

Guest Faculty:

Grant Liddle, M.D.  
Professor and Chairman,  
Department of Medicine  
Vanderbilt University School of Medicine  
Nashville, Tenn.

Frank A. Finnerly, Jr., M.D.  
Professor of Medicine  
Georgetown University Medical Center  
Washington, D. C.

Henry D. McIntosh, M.D.  
Professor and Chairman,  
Department of Medicine  
Baylor University School of Medicine  
Houston, Texas

James L. Quinn, III, M.D.  
Professor of Radiology  
Northwestern University Medical School  
Chicago, Ill.

A.A.G.P. Credit Requested

For further information and Curriculum: Department of Medicine  
Temple University Health Sciences Center  
3401 North Broad Street  
Philadelphia, Pennsylvania 19140  
Sol Sherry, M.D.  
Chairman, Department of Medicine  
Albert J. Finestone, M.D.  
Director of Course

**Symposium on Peripheral Arterial Disease**  
**Current Concepts of Diagnosis, Medical and Surgical Treatment, Prosthetic Applications**  
**Friday, October 27 and Saturday, October 28, 1972**  
**Temple University Health Sciences Center**  
**Department of Rehabilitation Medicine and Rehabilitation Research and Training Center**

Location of course and accommodations: Temple University Conference Center,  
9230 Germantown Avenue, Philadelphia, Pennsylvania (Chestnut Hill Area)

A comprehensive two-day symposium on pathophysiology of altered hemodynamics, intravascular thrombosis, and arterial degeneration. Current and advanced techniques of: diagnosis, medical and surgical treatment, comprehensive consideration of lower extremity, amputation techniques, immediate post-operative and standard prosthetic techniques and recent prosthetic advances with their neurophysiological implications. Guest Faculty consisting of nationally recognized authorities.

Course Credits: Applied for Pennsylvania and AMA Academy of Family Physicians

Registration limited to 150—Physicians \$100.00, Residents: \$50.00

Overnight accommodations available—Room and meals included.

(Meals only: Lunch—\$5.00, Dinner—\$8.00)

Double Occupancy: \$30.00 (meals included)

Single Occupancy: \$37.00 " "

Inquiries: Department of Rehabilitation Medicine, Temple University Health Sciences Center,  
3400 North Broad Street, Philadelphia, Pennsylvania 19140  
Phone: 215-221-3636.

# 6,500 New Jersey Physicians have voted for Prevailing Fees...

## Have you?

Over 6,500 New Jersey physicians have joined the Blue Shield Prevailing Fee Program. Have you?

If not, this message is directed to you — especially if you are among the nearly 1,300 Participating Physicians in Blue Shield's Basic program who have not yet signed up for Prevailing Fee. Surely those who support the service benefits concept under a less than usual and customary fee schedule should welcome a service benefits program that pays usual and customary fees.

Many of those 1,300 Basic Participating Physicians may be wondering why some payments for their services are going to subscribers and not to them. The reason is that only Prevailing Fee Participating Doctors are paid direct for services to Prevailing Fee subscribers; Prevailing Fee is a separate program with a separate participation agreement.

Prevailing Fee — which should become the dominant Blue Shield program — does more for both the physician and subscriber. The Participating Doctor receives his usual and customary fees — direct from

the Plan — for covered services. The subscriber, regardless of his income, receives paid-in-full coverage for eligible services from a Participating Doctor.

For Prevailing Fee to reach its full potential the widest possible participation by physicians is essential. Subscriber groups must have widespread availability of paid-in-full coverage, through Participating Doctors, to justify the higher premium required for Prevailing Fee. The more physicians that participate, the more groups will purchase Prevailing Fee, and the more payments of usual and customary fees, rather than basic scheduled fees, will be made to Participating Doctors.

Ask a Physician Relations representative to call on you and explain Prevailing Fee in detail. You may be pleasantly surprised at how easy it is to start receiving payment of your usual and customary charges direct from Blue Shield for Prevailing Fee patients.

Just call collect (201) 456-3250. You'll be glad you did.



**BLUE SHIELD**

Medical-Surgical Plan of New Jersey

# Librium® and (chlordiazepoxide HCl) concomitant use

Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, anti-hypertensive agents, diuretics, anticholinergics and antacids.

**Antianxiety effectiveness:** Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling

are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable appropriate levels.

**Effect on mental acuity:** Usually minimal on proper maintenance dosage.

**Safety:** An excellent clinical record. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

LIBRARY

AUG 22 1972

NEW YORK ACADEMY  
OF MEDICINE

in relief of clinically  
significant anxiety

**Librium®**  
(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules  
up to 100 mg daily in  
severe anxiety

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debili-

tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. These ble in most instances by proper adjustment, but are also encountered at the lower dosage rare few instances syncope has been. Also encountered are isolated skin eruptions, edema, minor irregularities, nausea and con extrapyramidal symptoms, increased decreased libido—all infrequently generally controlled with dosage; changes in EEG patterns (fast activity) may appear during treatment; blood dyscrasias (inc agranulocytosis), jaundice and dysfunction have been reported ally, making periodic blood count liver function tests advisable during therapy.

**Supplied:** Librium® capsules contain 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets contain 10 mg or 25 mg chlordiazepoxide

ROCHE

Roche Laboratories  
Division of Hoffmann-La Roche Inc  
Nutley, N.J. 07110

New York, New York 10029 C



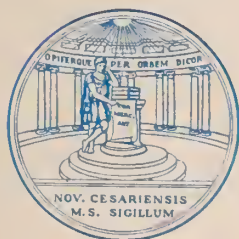
the

## JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

## contents

Pages 709 to 802



## EDITORIALS

Interested Only in Our Profession?	725
If You Had a Terminal Illness	725
The Work Addict . . .	725

## ORIGINAL ARTICLES

Narcotic Addicts and Their Newborns Theodore Kushnick, M.D., et al., Newark	727
Management of Ophakia . . . . . Owen Belmont, M.D., Philadelphia	733
Polycystic Liver Disease in Two Sisters Stephen M. Levine, M.D. et al., Camden	743
Lithium in Treatment and Prevention of Affective Disorders Granville L. Jones, M.D. and Sergio D. Estrada, M.D., Summit	747
Disodium Cromoglycate . . . . . Michael S. Mattikow, M.D., Wayne	753
Heartburn . . . . . Norman Riegel, M.D., Paramus	755
Depression and Pain Treated by Modified Prefrontal Lobotomy Arthur Winter, M.D., East Orange	757
Talcum Granuloma . . . . . D. R. Patel, M.S. and Shigeo Kondo, M.D., Orange	763
Private Practice in the Face of Prepaid Health Care Lee S. Goldsmith, M.D., L.L.B., New York	767

## SPECIAL ARTICLE

Medical School's Board of Concerned Citizens College of Medicine and Dentistry of New Jersey	773
---	-----

## NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes: July 16, 1972	777
Amalgamation of Internal Medicine Organizations	782
Communicable Diseases in New Jersey	783
Medical College Notes	784
Committees and Councils—1972-1973	787
Special Committees and Liaison Representatives—1972-1973	790

## ANNOUNCEMENTS

## OBITUARIES

## BOOK REVIEWS

794
796
799

# THE MEDICAL SOCIETY OF NEW JERSEY

## Endorsed Insurance Plans

### ACCIDENT AND HEALTH INSURANCE

**\$1,200** a month maximum BASIC total disability benefit.  
Accident: from 1st day, up to 5 years (Partial Accident  
Disability, half benefit up to six months)  
↓  
**PLUS** Sickness: from 8th day, up to 2 years  
Accident: may be EXTENDED to Lifetime  
Sickness: may be EXTENDED to 7 years  
↓  
**\$1,000** a month maximum NEW LONG-TERM PLAN.  
Payable up to Lifetime for accident—Age 65 for sickness  
Choice of waiting periods:  
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

★ ★ ★

### LIFE INSURANCE

**\$10,000 to \$150,000** of Convertible Term Life Insurance  
(Guaranteed exchangeable at any time into Permanent Cash  
Value life insurance without medical examination)

**\$10,000 to \$50,000** of Convertible Term Life Insurance  
available for spouse, dependent children  
and employees.

★ ★ ★

### MAJOR EXPENSE INSURANCE

**\$25,000** maximum for Covered Expenses as stated in the policy for each  
accident or sickness, covering member, spouse, and eligible  
children. \$750 deductible, 20% co-insurance. (Physicians' and  
surgeons' fees are not a Covered Expense.)

★ ★ ★

### HOSPITAL-MONEY PLAN

**\$20-\$30-\$40** per day paid for each day that you or your dependents  
are hospitalized, from the first day for as long as 365  
days for any one accident or sickness. Benefits are tax-free.

★ ★ ★

### SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

**\$200,000** maximum for member, covering accidental death, dismember-  
ment, loss of sight, total and permanent disability, exposure  
and disappearance. **\$100,000** maximum for spouse (without  
disability benefit).

★ ★ ★

**H.R. 10 (KEOGH) RETIREMENT PLAN ★ ★ CORPORATE MASTER PLAN**

#### APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations  
for acceptance of risks. New members have special privileges during the first  
few months of membership; ask for specific details if you were recently elected  
or have applied for membership.

*Information and claim service are as close as your telephone.*

**E. & W. BLANKSTEEN AGENCY, INC.**

75 MONTGOMERY STREET, JERSEY CITY, NEW JERSEY 07302

(201) DElaware 3-4340



# Look what comes with your Rossmoor home.



## Your own 18-hole par-71 course!

Imagine having an 18-hole, par-71 course with PGA pro right in the community were you live. Within walking distance of your home. Where you can play as frequently as you wish without fighting your way through miserable traffic; without interminable delays waiting to tee off. At a nominal yearly fee that's only a tiny fraction of the cost of joining a golf or country club.

That's the wonderful world of Rossmoor. Designed for active adults 48 years and over, retired or not.

But golf isn't the only attraction in this unique community. There's

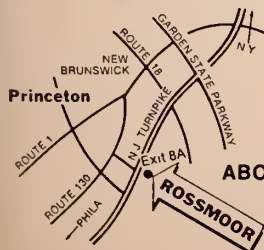
tennis. And swimming in an olympic-size pool. And so many other recreation activities, you'd need a 10-day week to fit them all in.

The real beauty of living at Rossmoor is that you have more time to enjoy all these pleasures. Though you have all the tax advantages and equity build-up that comes with home ownership, you have none of the chores. All the exterior work is done for you here. A trained staff fertilizes, limes and mows your lawn, rakes the leaves, shovels the snow and maintains the exterior of your home.

You also have perfect peace of mind here because Rossmoor is a protected community. With a gateman and a roving security force that protects you 24 hours a day.

If you think it costs a fortune to live here, we have great news for you. The condominium manor homes with 2 bedrooms and 2 baths, G. E. appliances and central air conditioning are priced from \$27,650.

Come live where all the active adults live. At Rossmoor. Where the 19th hole more than likely will be located on your own patio.



*The adult community for active people.*  
**Rossmoor**  
 Monroe Township, N.J. / (609) 655-2270  
 AT EXIT 8A OF THE NEW JERSEY TURNPIKE



Sponsored and developed by  
 GUARDIAN DEVELOPMENT CORP., a publicly-owned company.



# Medicine and Blue Shield Need Each Other

Medicine and Blue Shield have come a long way together. This was the reflection of Ned F. Parish, President of the National Association of Blue Shield Plans, as he addressed this year's business meeting of the 71 Member Plans. Parish emphasized the importance of a close relationship between Blue Shield and Medical Societies in his remarks, excerpts of which are contained in the following.

Blue Shield was organized by physicians over three decades ago, but it is clear in every document and from the memories of those who were around at the time, that these physicians helped establish Blue Shield as the Doctors' Plan to serve the public.

There is no greater monument to the spirit and dedication of doctors than Blue Shield. Every physician can be proud that he is a member of a profession that shares a major responsibility for helping to build a strong system that provides the public with relatively easy access to medical care.

But, he must also know that it does not belong to him. Nor to the Blue Shield Plans. It belongs, instead, to those 66 million Americans who are now joined together to form a non-profit health protection organization known as Blue Shield.

Communications between the profession and the public can be improved by making sure that both fully understand Blue Shield's role in health care.

This can be accomplished by cooperation between the medical profession and Blue Shield.

Let's try to solidify our front through a little better understanding of the mutual contributions each has made.

Simply stated, *the medical profession's outstanding contributions to Blue Shield* include the following:

1. It helped Blue Shield get established—to repeat—for the benefit of the public.
2. In certain Plan areas, the medical profession accepted reduced payments to keep the Plan from financial disaster.
3. The physicians contribute untold hours to Blue Shield Board and committee functions—without payment—to develop programs that the public needs.
4. Medicine has also provided peer review committees to help establish claims review guidelines and to adjudicate the tough cases.
5. Physicians signed participating agreements with Blue Shield—individually or through medical societies. This gave Blue Shield an opportunity to help itself and the medical profession to be of greater service to the public.

What have the *Blue Shield Plans* done for Medicine? An equally impressive list can be drawn.

1. Blue Shield has given the leadership to, and participated largely in, the development of the world's largest and most viable private system for the delivery and financing of medical care.
2. It has assured direct payment to Participating Physicians without losses from bad debts and without additional collection expense. Today, on private business alone, Blue Shield pays doctors more than 2½ billion dollars a year.  
  
(NOTE: In New Jersey, the figure is nearly \$90 million a year)
3. Blue Shield—through the physician voice on Boards and committees and through cooperation by medical societies—has been receptive to and molded by Medicine's views.
4. It has undertaken experimental activities to extend prepayment coverage into new areas of delivering medical services.
5. Blue Shield is working with medical society assistance to develop more effective utilization of the medical care dollar.

Blue Shield, by providing the public easy access to medical care through its Participating Physicians and its pre-payment insurance concept, has been a major bulwark of the American system of private medical care. Without it we almost certainly would now have a national health insurance program — federally financed and administered, with fees set by the government — similar to the British National Health Service. Proponents of national health insurance continually preach of the great success of the British National Health System. The facts are, however, that over two million persons have joined the British United Provident Association — an associate member of the National Association of Blue Shield Plans — so that they can continue to select their own private physicians. At present BUPA is growing more rapidly, percentage-wise, than any other Blue Shield Plan.

From the above, it is obvious that Blue Shield and physicians, working together, can improve — and have improved — the delivery of medical care by providing the American public with a voluntary system which preserves a close doctor-patient relationship.

**BLUE SHIELD**  
Medical-Surgical Plan of New Jersey



# THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

## Officers and Trustees

### PRESIDENT

William J. D'Elia, M.D. (Monmouth) ..... Neptune City

### PRESIDENT-ELECT

Matthew E. Boylan, M.D. (Hudson) ..... Jersey City

### FIRST VICE-PRESIDENT

James A. Rogers, M.D. (Passaic) ..... Paterson

### SECOND VICE-PRESIDENT

John J. McGuire, M.D. (Essex) ..... Newark

### IMMEDIATE PAST-PRESIDENT

E. Vernon Davis, M.D. (Burlington) ..... Mount Holly

### SECRETARY

Louis F. Albright, M.D. (Monmouth) ..... Spring Lake

### TREASURER

Samuel J. Lloyd, M.D. (Mercer) ..... Trenton

## Trustees

### CHAIRMAN

A Guy Campo, M.D. (1973) (Gloucester) ..... Westville

### SECRETARY

David Eckstein, M.D. (1975) (Mercer) ..... Trenton

Robert C. Anderson, M.D. (1975) (Essex) ..... Newark

Francis J. Benz, M.D. (1973) (Morris) ..... Chatham

George L. Benz, M.D. (1974) (Essex) ..... Newark

Edward J. Bourns, M.D. (1975) (Union) ..... Westfield

Harold L. Colburn, Jr., M.D. (1973) (Burlington) Mount Holly

Charles L. Cuniff, M.D. (1975) (Hudson) ..... Jersey City

Richard E. Lang, M.D. (1975) (Passaic) ..... Passaic

Nicholas E. Marchione, M.D. (1974) (Cumberland) Vineland

I. Edward Orna, M.D. (1975) (Camden) ..... Camden

Howard D. Slobodien, M.D. (1975) (Middlesex) Perth Amboy

James S. Todd, M.D. (1974) (Bergen) ..... Ridgewood

## Councilors

### FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Thomas S. P. Fitch, M.D. ..... Plainfield (1975)

### SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

John L. Olpp, M.D. ..... Englewood (1974)

### THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. ..... Trenton (1973)

### FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. ..... Haddonfield (1975)

### FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

John S. Madara, M.D. ..... Salem (1974)

## AMA Delegates

Joseph P. Donnelly, M.D. (1973) ..... Jersey City

Frank J. Hughes, M.D. (1974) ..... Gloucester

John E. Kustrup, M.D. (1974) ..... Trenton

Luke A. Mulligan, M.D. (1974) ..... Leonia

Isaac N. Patterson, M.D. (1973) ..... Westville

Emmanuel M. Satulsky, M.D. (1974) ..... Elizabeth



September 1972

## Publication Committee

Daniel B. Roth, M.D., *Chairman*

Arthur Krosnick, M.D.

John F. Marshall, M.D.

## Editor

Henry A. Davidson, M.D.

## Assistant Editor

Marjorie D. Treptow

## Advertising Manager

Joseph W. Cookson

## Executive Director

Richard I. Nevin

*The Journal* is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 817.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription (\$3.50) is included in the dues of Society members.

Subscription rates for nonmembers: \$7 per year (including postage), in advance. Outside USA, postage is additional.

Single copies are \$1.00 each.

Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

Second class postage paid at Trenton, New Jersey, and additional entry office.

Copyright 1972 by The Medical Society of New Jersey.



# Why send him to the islets of Langerhans?



Since sulfonylureas promote the release of insulin which is lipogenic and helps transport glucose into adipose tissue...

And since many overweight patients already have normal or high levels of endogenous insulin, why not consider DBI-TD?

It lowers blood sugar without stimulating

insulin secretion from the pancreas. And this may be important to the dieting diabetic.

In adult-onset, nonketotic diabetics uncontrolled by diet alone...

**DBI-TD<sup>®</sup> Geigy**  
**phenformin HCl**

lowers blood sugar without raising blood insulin.

#### **DBI<sup>®</sup> phenformin HCl**

Tablets of 25 mg.

#### **DBI-TD<sup>®</sup> phenformin HCl**

Elmed-Disintegration

Capsules of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.** 2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic

determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin. **Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-D (6/72)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of  
CIBA-GEIGY Corporation  
Ardsley, New York 10502





# a new outlook in chronic pain

of moderate to severe intensity

Though Talwin® Tablets, brand of pentazocine (as hydrochloride), can be compared to codeine in analgesic efficacy, Talwin is not subject to narcotic controls. Patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with meperidine or codeine. And that, in the long run, can mean a better outlook for your chronic-pain patient.

#### Talwin Tablets are:

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe—day or night—even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, light-headedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

**Talwin**®

brand of

**pentazocine** (as hydrochloride)

the long-range analgesic



# a new outlook in chronic pain

of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

**Usage in Pregnancy.** Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

**Drug Dependence.** There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

**Acute CNS Manifestations.** Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

**Usage in Children.** Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Ambulatory Patients.** Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions: Certain Respiratory Conditions.** Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

**Impaired Renal or Hepatic Function.** Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

**Myocardial Infarction.** As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

**Biliary Surgery.** Until further experience is gained with the effects

of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract. *Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

**CNS Effect.** Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration: Adults.** The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

**Children Under 12 Years of Age.** Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Duration of Therapy.** Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage: Manifestations.** Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

**Treatment.** Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are not effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®) may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg base. Bottles of 100.

**Winthrop** Winthrop Laboratories, New York, N. Y. 10016 (1583)

50 mg. Tablets

**Talwin®**  
brand of  
**pentazocine** (as hydrochloride)

the long-range analgesic



## Are they too old to swing?

### EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol .....	0.005 mg.
Methyltestosterone .....	1.25 mg.
L-lysine .....	100 mg.
Ferrous Nicotinate .....	17.85 mg.
Equivalent to Nicotinic Acid .....	12.5 mg.
Ferrous Iron .....	2.82 mg.
Vitamin A .....	2,500 U. S. P. Units
Vitamin D .....	250 U. S. P. Units
Thiamine Mononitrate .....	2.5 mg.
Riboflavin .....	2.5 mg.
Ascorbic Acid .....	25.0 mg.
Folic Acid .....	0.125 mg.
Vitamin B-12 .....	1.5 mcg.
Methionine .....	12 mg.
Choline Bitartrate .....	15 mg.
Inositol .....	10 mg.
Calcium Pantothenate .....	2.5 mg.
Pyridoxine .....	0.25 mg.
Copper (from Copper Sulfate) .....	0.25 mg.
Zinc (from Zinc Oxide) .....	0.25 mg.
Iodine (from Potassium Iodide) .....	0.075 mg.
Calcium (from Dicalcium Phosphate) ..	72.5 mg.
Phosphorus (from Dicalcium Phosphate) .....	55 mg.
Potassium (from Potassium Sulfate) ..	2.5 mg.
Manganese (from Manganese Sulfate) ..	0.5 mg.
Magnesium (from Magnesium Sulfate) ..	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

**ACTION AND USES—DOSAGE:** 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 30, 100, and 500 tablets. Rx only.

## Testand-B tablets

*A hormonal, nutritional supplement*

**Geriatric Pharmaceutical Corp.**  
Floral Park, New York 11001  
*Pioneers in Geriatric Research*





# Announcing Roche Clinical Laboratories

Professional  
Consultation

An Advanced  
Diagnostic Center for  
Standard, Endocrine  
and Special Laboratory  
Tests

Automated Diagnostic Analysis  
for most tests





# A New Commitment in Health Care

**A new technological achievement that offers a broad scope of diagnostic testing. Designed to provide you, your patients and your hospital with highest quality test standards for better health-care delivery.**

**Simplified specimen preparation, daily pickup or prepaid mail, and permanent report forms are all part of this rapid, accurate diagnostic service.**

**The Roche Professional Representative welcomes the opportunity to introduce our laboratory service to you. Please fill in the coupon below for additional information.**

**Computerized  
Quality Control  
to prevent error**

**Personal Service through  
Roche Professional Representatives**

**ROCHE**

**Roche Clinical Laboratories  
1 Fairfield Crescent  
West Caldwell, New Jersey 07006**

Gentlemen

I am interested in learning more about  
Roche Clinical Laboratories Services

☐ Please send the Roche Clinical  
Laboratories Reference Manual

☐ Please have a Roche Professional  
Representative contact me

Doctor

Address

City

State

Zip

Tel No

**A Unique Professional  
Staff of Research  
Scientists and Practicing  
Clinicians**

# THE COLD RUSH OF '72

Meet it with **Cerose<sup>®</sup>** for coughs of colds



*Exempt Narcotic*

**CEROSE<sup>®</sup>** for relief of coughs due to colds, whenever an antitussive formulation having sedative, decongestant, antihistaminic, and expectorant actions is required

Each 5-cc. teaspoonful contains: codeine phosphate, 10.0 mg. (*Warning:* May be habit forming); phenindamine tartrate, 10.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, grape-flavored base, alcohol 2½%

*Non-narcotic*

**CEROSE-DM<sup>®</sup>** for relief of coughs due to colds. It diminishes the cough reflex, promotes expectoration, and provides effective vasoconstriction and bronchodilatation. Contains non-narcotic dextromethorphan

Each 5-cc. teaspoonful contains: dextromethorphan hydrobromide, 10.0 mg.; phenindamine tartrate, 5.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, mixed fruit-flavored base, alcohol 2½%



*Exempt Narcotic*

**CETRO-CIROSE<sup>®</sup>** for relief of simple coughs where a plain sedative-expectorant is required. An excellent vehicle for many other commonly employed adjunctive cough medications, as preferred by the physician

Each 5-cc. teaspoonful contains: codeine phosphate, 5.0 mg. (*Warning:* May be habit forming); fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, cherry-flavored base, alcohol 1½%

**IVES LABORATORIES INC.**

New York, N.Y. 10017



DEDICATED TO IMPROVING THE QUALITY OF LIFE, THROUGH MEDICINE

*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*— George Sarton, from "The History of Medicine Versus the History of Art"*

**Would it be useful  
in clinical practice to have  
government predetermine  
drugs of choice?**

# Opinion

**Results of a survey of physicians:**

**13.3%**

**Yes, it would be useful.**

**86.7%**

**No, it would not be useful.**

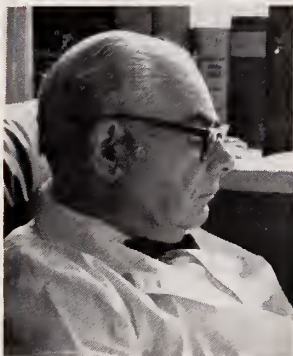


# Dialogue

## Would it be useful in clinical practice to have government predetermine drugs of choice?

### Doctor of Medicine

Walter Modell, M.D.,  
Professor of Pharmacology,  
Cornell University  
Medical College,  
Editor,  
Clinical Pharmacology  
& Therapeutics,  
Drugs of Choice,  
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial dif-

ferences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain

segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy

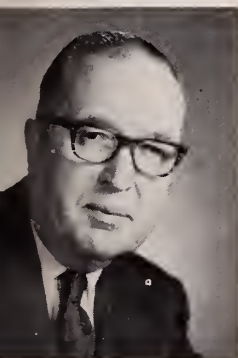
in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. As I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the "drug of choice" in all areas of medical practice.

# Maker of Medicine

Nath G. Kohlstaedt, M.D.,  
Vice President,  
Medical Research,  
Lilly and Company



In my opinion, it is not the function of any government or private regulatory agency to designate a "drug of choice." This determination should be made by the physician after he has received full information on the properties of a drug, then it will be based on experience with this drug and his knowledge of the individual patient who is seeking treatment. An evaluation of comparative efficacy were to be made, particularly by government, at the time a new drug is being approved for marketing, it would be a great disservice to medicine and thus to the patient and the consumer. For example, when a new therapeutic agent is introduced, on the basis of limited knowledge, it may be considered to be more potent, more effective, or safer than products already on the market. Conceivably, at the time the new drug is labeled "the drug of choice." But as additional clinical experience is accumulated, new evidence may become available. If, it may be apparent

that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B<sub>12</sub> as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. How-

ever, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "drugs of choice" is to be avoided.

## Opinion & Dialogue

What is your opinion, doctor?

Send us your comments on the above issue.



The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005





**Not too little, not too much...  
but just right!**

"Just right" amounts of Ilosone Liquid 250  
can be dispensed easily from the pint bottle in *any* quantity  
you specify to meet your patients' precise needs—  
without regard to package size.

ready-mixed  
**Ilosone® Liquid 250**

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

*Additional information available  
to the profession on request.  
Eli Lilly and Company  
Indianapolis, Indiana 46206*



100204



---

# EDITORIALS

---

## Interested Only in Our Profession?

"I have heard a doctor say on occasion, 'I'm interested only in my profession; I'm not interested in politics.' Let me tell you something. He better get interested in politics or he won't have any profession to be interested in." . . . .  
Richard Nixon

A blunter warning or one from a more authoritative source could scarcely be found. The message is clear and rather disturbing: elect legislators who will listen to the voice of medicine *this year* or see the practice of medicine, as we now know it, doomed.

This is the place for forthright statements, not pious platitudes or circuitous generalizations. During the past year our profession may have become involved in politics of a purely parochial nature. But it brought results and served as a model for what we must do during the coming year on a broader scale. We must broaden our horizon to support legislators who think rationally rather than emotionally or politically on the entire spectrum of legislation as it relates to government planning, financing, monitoring, and controlling health services.

This kind of activity is built into the warp and woof of democracy. Let us live by it!

## If You Had a Terminal Illness

Suppose you yourself realized that you had a terminal illness. What would *you* want done? A Duke University Professor of Medicine wrote the following memorandum (as reported in the April 7, 1972, *Medical World News*). Would you agree? The memorandum was left with the doctor's wife and his attorney.

"In the event of unconsciousness from an automobile accident, I do not wish to remain in a hospital for longer than two weeks without full recovery of my mental faculties. While I realize that recovery might still be possible, the risk of living without recovery is still greater. At home, I want only one practical nurse. I do not wish to be tube-fed or given intravenous fluids at home.

"In the event of a cerebral accident, other than a subarachnoid hemorrhage, I want no treatment of any kind until it is clear that I will be able to think effectively. This means no stomach tube and no intravenous fluids.

"In the event of a subarachnoid hemorrhage, use your own judgment in the acute stage. If there is considerable brain damage, send me home with one practical nurse.

"If, in spite of the above care, I become mentally incapacitated and have remained in good physical condition, I do not want money spent on private care. I prefer to be institutionalized, preferably in a state hospital.

"If any other things happen, this will serve as a guide to my own thinking.

"Go ahead with an autopsy with as little worry to my wife as possible. The crematory (at the medical school) seems a final solution."

## The Work Addict

Give Americans Wednesdays off! That's my suggestion to the Senators who passed the \$1.47-billion bill looking for a cure for heart disease. Work is the cause of our heart attacks! That's my word to the researchers who will man the "model heart disease prevention centers" and the basic research centers the money will build and staff.

Forget about obesity, high cholesterol, and excessive smoking. They are simply friends of the killer, incidental to the addiction Ameri-

cans have for work. They are, if anything, the result of the victim's attempt to escape.

Work is the real killer. It provides the stress. And coronary disease is a stress disease. Like ulcers and colitis and emotional breakdowns, it results from an overload, either physical or mental. The patient blows a fuse. Some are like 220 lines and can handle more than others. But all eventually blow. And work usually supplies the decisive amount of stress.

Work (no matter how management, the psychologists, and the Harvard Business School men try to dress it up) remains the main source of stress in a person's life. It also remains for most of us a satisfying and important human activity. Only through work can many of us find creativity, self-expression, self-esteem, and feelings of security. Work, said Freud, was essential to mental health. It absorbed, he thought, hostility and aggression. Tense, coronary-squeezing, frustration-filled work also satisfies our need to be with people. Psychiatrists and psychologists have introduced ways to make people feel responsible, wanted, and important. But they forgot one thing. We are bodies.

Psychologists and Harvard Business alumni tend to forget about a man's guts. They ignore his heart, arteries, his colon, and duodenal bulb. But a man's internal milieu, that miraculous balance of water and salts and hormones, is as much at issue as his emotional adjustment. The forty-hour week has come about through a mixture of management concessions and union demands. Originally more humane motives produced changes. But non-union man had to reach the mid-1800's to have the ten-hour law passed. What seemed quite logical and sound to a civilization of common sense now seems absurd in an age of specialization. So we see Lipton's management introducing a 12-hour day in their New Jersey plants. Sooner or later such idiocy will demand the examination of physiologists who know how to measure the effects of stress on the body. Actually, the ideal work day and the ideal work week varies from person to person.

This ideal schedule, it seems to me, will have not more than two, certainly no more than three, work days in a row. Few people can put four days in succession, much less five. On the fifth day or possibly the fourth, work which exists for man's survival becomes a killer. That is the crux of the situation.

That's where Wednesday comes in. A day to adapt. A day to meditate. Sunday is for God, Saturday is for play, Wednesday is for self. Wednesday puts the rest of the week, even the rest of your life in perspective. Used for reading, self-improvement, or simply contemplating the sky, it tells you what your job really means and where it fits in the scheme of things.

Some are aware even now of the need for this break in the week—the French, for instance, although their concern is not for themselves, but for their children. The decibel levels of conversations all over France have been raised because of an attempt to change the present school schedule where the children go to school on Saturday and have Thursday off. The move is opposed by teachers (the fatigue of five straight days, they say, would be too much for them). A group of 49 French physicians reported that children's health would suffer from going to class five days in a row. A priest warned that compressing the school week would cause stupefying work and an explosion of "animal leisure." More positive was a letter to *Le Monde*. "Thursday," it said, "is the day of the Boy Scouts, the piano lesson, the model plane club, or the big game, or even an in-depth study of Mao's thoughts."

There's the answer. The best method of coping with stress is in the self-expression only Wednesday can bring. That special sanity that comes in the middle of the week when man can stand back from God and country and family and work, and for 24 hours just be himself.

George Sheehan, M.D.

Abstracted from *The Daily Register*, Red Bank, (N.J.)  
12 April 1972.

# ORIGINAL ARTICLES

*Chromosome breakage rate was found increased in opiate addicts, but little of this breakage appears to have been passed on to their newborn offspring.*

## Narcotic Addicts and Their Newborns\*

Theodore Kushnick, M.D., Marcy Robinson, M.S., and Carrie Tsao, B.S./Newark

In 1969, our Martland Hospital Unit developed a drug abuse unit for the treatment of narcotic addicts. Cytogenetic studies were then performed on adult male and female addicts as well as the newborn offspring of the pregnant addicts. All of the adults were addicted

some analyses were done, utilizing a modification of the method of Moorhead, *et al.*<sup>1</sup> Chromosome breakage and mitosis rates were studied according to the methods of Cohen, *et al.*<sup>2</sup> Buccal smears for sex chromatin patterns were determined with aceto-orcein staining.

As indicated in the table, there was a signifi-

Chromosome Breakage and Mitosis Combined Adult and Newborn Data

	Number	% Breaks (Range)	% Mitosis (Range)
Controls	46	$2.49 \pm 0.27$ (0 — 9.8)	$6.81 \pm 0.43$ (1.9 — 16.6)
Addicts	78	$5.10 \pm 0.29$ (0 — 16.0)	$6.10 \pm 0.23$ (2.5 — 12.1)
		$p < 0.001$	N.S.*

Chromosome Breakage and Mitosis in Adult Controls and Addicts

	Number	% Breaks (Range)	% Mitosis (Range)
Controls	31	$2.08 \pm 0.26$ (0 — 6.0)	$7.58 \pm 0.53$ (4.1 — 13.9)
Addicts	60	$5.01 \pm 0.30$ (0 — 16.0)	$6.30 \pm 0.22$ (2.3 — 11.7)
		$p < 0.001$	$p < 0.02$

Chromosome Breakage and Mitosis in Newborn Controls and Infants of Addicts

	Number	% Breaks (Range)	% Mitosis (Range)
Controls	15	$3.35 \pm 0.59$ (0.7 — 9.8)	$5.22 \pm 0.53$ (1.9 — 9.1)
Infants of Addicts	18	$5.38 \pm 0.78$ (1.3 — 12.3)	$5.43 \pm 0.57$ (2.8 — 12.1)
		N.S.*	N.S.*

\* Not Significant

to heroin and users of other drugs as well. Purpose of the investigation was to determine if there were increased chromosomal breakage rates and reduced mitosis rates in these patients. Chromosome counts, karyotypes, and sex chromatin patterns were studied to determine if underlying aberrant chromosomal constitutions might be present with increased frequency in drug abusers.

The patients studied included 60 adult narcotic addicts; 18 newborn offspring of addicted mothers; 31 adult and 15 newborn controls.

Peripheral lymphocyte cultures and chromo-

somes were studied in the newborns. A significant increase in chromosome breakage in the addicts and their offspring compared to the controls, when the data were combined for adults and newborns. When the results were studied with respect to adult and newborn status, the chromosome breakage rate was very significantly increased for the adult addicts

\* This work is from the Departments of Pediatrics and Preventive Medicine, College of Medicine and Dentistry of New Jersey at Newark. Dr. Kushnick is Professor of Pediatrics, and the other authors are Cytogenetic Research Assistants, Division of Drug Abuse, Department of Preventive Medicine. This project was supported by Grant No. 5H19-MH 17843-02 from the National Institute of Mental Health, Public Health Service Division, Department of Health, Education and Welfare.



( $p < .001$ ) but there was no significantly increased breakage in newborn infants of addicts as compared to controls. As demonstrated in the table, significant reduction in mitosis rate occurred only in the adult addicts. No abnormal chromosome configurations or constitutions were noted in any of the groups.

An increased chromosomal breakage rate in users of L.S.D. and narcotics has been noted in previous studies,<sup>2,3</sup> with findings similar to those reported in this investigation. There were no increased breakage rates in the newborns of drug users as reported by Berlin and Jacobson,<sup>3</sup> or as demonstrated in this study. This investigation *did* demonstrate a reduced mitosis rate in the adult addicts. The meaning of these abnormalities has not been established, although there has been an increased incidence of central nervous system malformations noted in the offspring of users of L.S.D. and other agents.<sup>3</sup>

To appraise the possible bases for these cytogenetic abnormalities, further studies are being performed using the addition of varying dilutions of narcotic drug packets (obtained from the toxicology division) to the leukocyte cultures from previously studied controls, and also by addition of serum hepatitis antigen to similar cultures. Previous cytogenetic investigations of patients with serum hepatitis have demonstrated an increase in chromosome breakage, but their mitosis rates were not studied.<sup>4</sup> In a similar study of patients with infectious hepatitis,<sup>5</sup> increased chromosomal

breakage and mitotic suppression were noted. It seems possible that any of these environmental agents or combinations of viruses and drugs might be responsible for the cytogenetic findings noted in our patients.

The only subject who could be followed for repeated studies was one 4 month old daughter of an addicted mother. This baby demonstrated a reversal from elevated breakage rate to normal levels, but her mitosis rate remained low.

### Summary

Cytogenetic studies were performed on 60 adult narcotic addicts and 18 newborn offspring of addicted mothers and compared with 31 adult and 15 newborn controls. No aneuploidy† was noted but the chromosome breakage and mitosis rates were significantly elevated and depressed respectively in the adult addicts. There was no significant difference in chromosome breakage and mitosis between the infants of addicts and newborn controls. The etiology for these abnormalities was not determined.

### Bibliography

1. Moorehead, P. S., Nowell, P. C., Mellman, W. J., Battips, D.M. and Hungerford, D.A.: *Exp. Cell Res.*, 20:613 (1960)
2. Cohen, M. M., Hirschhorn, K. and Frosch, W. A.: *New Eng. J. Med.*, 277:1043 (1967)
3. Berlin, C. M. and Jacobson, C. B.: In Discussion of Congenital Anomalies Associated with Parental L.S.D. Ingestion. Presented at the Society for Pediatric Research, Atlantic City, N.J., April 1, 1970
4. Makino, S. and Takao, A.: *Cytologia*, 33:370 (1968)
5. Mella, B.: *Neurol.*, 18:741 (1968)

†A state of having more or less than the normal diploid number of chromosomes.

100 Bergen Street

## PATRONIZE OUR ADVERTISERS

They Merit Your Support

Prompt relief of pain is a lot of what the practice of medicine is all about... East or West.

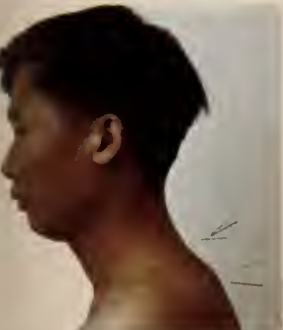
In much of the Far East, the analgesic efficacy of Empirin® Compound with Codeine would probably be measured against acupuncture, an ancient and traditional therapeutic system.

In America, codeine sets such a high standard for oral analgesia, that it has become a criterion in terms of which other major oral analgesics are most often measured.


Synthetic and other oral analgesics may offer some of the properties of codeine, but not one can provide both its benefits and potency. And codeine provides an antitussive bonus.

#### Empirin Compound with Codeine

is the most widely used, and probably the most pharmaceutically elegant analgesic preparation providing codeine. It's the time-tested combination for predictable pain relief... whether the pain is visceral or musculoskeletal; acute or chronic.

 **New prescription flexibility.** At your discretion, and where state law permits, a prescription for Empirin Compound with Codeine may now be refilled up to five times in six months.

*Empirin Compound with Codeine No. 3 contains codeine phosphate\* (32.4 mg.) gr. 1/2. No. 4 contains codeine phosphate\* (64.8 mg.) gr. 1. \*(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3 1/2, phenacetin gr. 2 1/2, caffeine gr. 1/2. Bottles of 100 and 1000.*



# But for relief of Western pain EMPIRIN® COMPOUND CODEINE







# Break the ulcer circuit to hyperacidity, hypermotility and ulcer pain.

## Pro-Banthine® propantheline bromide A Relief Factor in Peptic Ulcer



Worry, frustration, job pressure—all set up excessive vagal currents in patients with peptic ulcer.

Pro-Banthine "insulates" the stomach, the duodenum and the lower intestinal tract—the sites where these destructive currents take their toll.

This "insulation" helps block excessive enteric activity and acidity, thus helping to provide the proper environment for the healing of peptic ulcers.

It's nice to know that Pro-Banthine provides this protection at a dosage that causes little or no discomfort and that, unlike antacid agents, Pro-Banthine does not cloud the patient's awareness or thought processes.

By moderating excessive vagal currents Pro-Banthine relieves spasm, acid burn and pain. By reducing gastric motility Pro-Banthine also prolongs the activity of antacids.

**Indications:** Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

**Contraindications:** Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis or unstable cardiovascular adjustment in acute hemorrhage.

**Warnings:** Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with possible loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males

with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

**Adverse Reactions:** Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

**Dosage and Administration:** The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

**How Supplied:** Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE

SEARLE & CO  
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.  
Medical Department, Box 5110, Chicago, Ill. 60680

# NEW FOR ULCER... LIQUID **MYLANTA-II**<sup>®</sup>

## GREATER NEUTRALIZING IMPACT

- ☐ more neutralizing action per  
teaspoonful than standard antacids
- ☐ without the acid rebound  
associated with calcium carbonate
- ☐ pleasant tasting / rapidly effective
- ☐ non-constipating / non-laxating

**MYLANTA-II**<sup>®</sup> LIQUID

aluminum and magnesium hydroxides plus simethicone

**NEW HIGH POTENCY ANTACID  
FOR RELIEF OF ULCER PAIN**



STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109



# Management of Aphakia\*

**Owen Belmont, M.D./Philadelphia**

One of my colleagues tells me that more than once he has asked a patient to leave his office, and do him the favor of not returning. Who are these patients? They are aphakes who once came to him because of failing vision from cataracts, then left him to go to someone else for cataract surgery, and now are returning because they are dissatisfied with their postoperative care. These patients point up the fact that aphakia is difficult to manage, and that patients are often dissatisfied with the way they are treated and, also, that their care is no great joy to the ophthalmologist either. Few problems in refraction can be more frustrating.

When we remove a cataractous lens, the only remaining refractive element is the cornea, so that the total refractive power of the eye is reduced from approximately 59 diopters to about 43 diopters. The crystalline lens, lying in aqueous, generates about 16 diopters. Nevertheless, the average aphakic correction, because it is glass or plastic, out in front of the eye about 12 mm., and in air instead of aqueous humor, need be only about 10 or 11 diopters.

Correction of aphakia by a spectacle lens results in image magnification of about 25 per cent. The nodal point of the spectacle-corrected aphakic eye is moved forward. Image magnification then results. Removal of the crystalline lens and substitution of a spectacle lens creates a sort of Galilean telescope. By removing the crystalline lens one gets the same effect that would result from superimposition of a minus 16 diopter lens in the same plane. Now we add a +10 lens about 12 mm. before the cornea. This provides the

elements of a Galilean telescope, a plus forward element and a minus element behind it. Looking out through this telescope, the aphake sees a magnified image. Looking at the fundus through a direct ophthalmoscope with a plus 10 lens, the observer is looking through an inverted telescope, so that the fundus details are minified.

The formula for magnification by such a telescope is:

$$M = \frac{1}{1 - tD_1} \text{ in which } M = \text{magnification}$$

$t$  = distance between + and - elements  
 $D_1$  = powers of the + elements in diopters

The greater the  $t$ , or distance between the plus and minus elements, the greater the magnification. It is for this reason that a contact lens, which greatly reduces the  $t$ , gives much less magnification than a spectacle lens.

The aphake has no accommodation but if his pupil is small he has some depth of focus. He is sensitive to glare, especially if he has a keyhole pupil, because the cataractous lens, now missing, formerly acted as a filter.

Benton and Welsh<sup>1</sup> have described the false orientation caused by spectacles in aphakia in four components, false depth, false projection, swim, and distortion. We have all seen newly aphakic patients reach for a test card and grope in thin air, as they project the image of the card closer than it is. We judge the distance of objects by their size, and the image of the card is magnified. Also, false projection causes the aphake to see things

\*Read before the Section on Ophthalmology, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 7, 1972.



more peripherally than they are, as well as closer.

As patients look from side to side, lines twist and writhe like snakes. Straight lines are seen in a pin cushion arrangement, curving out in the periphery. This is caused by spherical aberration, since spherical lenses have greater deviating power at their periphery than near their center. As he rotates his eye the lines of the pin cushion writhe, and he suffers from swim. Distortion is the sum of the complex interaction of false projection, false depth, and swim.

The ring scotoma of aphakic corrections occurs with any very strong convex lens, and creates the "jack-in-the-box" phenomenon. Between the outermost light ray passing through and refracted by the periphery of the lens and the adjacent ray of light which just misses the periphery of the lens and is not refracted by it, there exists a blind area of about 15 angular degrees. This forms the ring scotoma, which is most crippling for activities between 2 and 10 feet from the patient. It does not interfere with close work or driving a car, but is most frustrating in a room full of people. As the eye rotates out, to fix an object seen peripherally, the scotoma rotates in, giving rise to the "jack-in-the-box" phenomenon: the object is first seen, then disappears, then reappears.

Patients for whom the side effects of aphakic glasses prove unbearable should, if possible, be fitted with a contact lens, as should monocular aphakes with good vision in the unoperated eye. Since wound healing is only partial in the early months after operation, I have adopted a four-month interval before fitting with a contact lens. This interval has proved safe. Eyes with round pupils are easier fitted than those with sector iridectomies; this must be weighed against the better fundus view with a keyhole pupil should the patient develop a retinal detachment.

Patients too tremulous or unwilling to be fitted with a contact lens pose a problem. We may advise them that the cataract should be

operated and kept as a spare, ready for use should the other eye ever lose its sight. The patient may seem to understand completely that he will not get his glasses for years to come. Repeated explanations bore him. After the operation, he talks with other patients, he talks with relatives who have friends who have been operated on for cataract. Now, at each postoperative visit he asks the same dismaying question, "Doctor, when will I get my cataract glasses?"

The late Carroll Mullen used to order an aphakic correction for the operated eye with a balance lens to blur the unoperated eye. He would tell the patient, "These are your television glasses. Wear them 10 minutes a day while watching television. Don't use them for anything else until I tell you to." This offered the patient some immediate benefit from his travail in the operating room and hospital.

Lubkin, Stollerman, and Linksz<sup>2</sup> published a paper on stereopsis in monocular aphakia with spectacle correction. They pointed out that two barriers to single binocular vision in monocular aphakia existed: first, image size difference, and second, prismatic disparity, causing diplopia when the eyes leave the primary position. Therefore, they said, one would expect comfort only in strabismus or high capacity for monocular suppression.

They corrected each eye, and added six prism diopters, base in, for each eye. They made the lenses as flat as possible, coated them against reflections, and gave separate reading glasses with an additional 2 to 4 prism diopters, base in. The patients were instructed to hold the reading matter high, so as to look through the optical centers. Four patients showed not only instrument stereopsis but were able to wear the lenses in everyday situations. This was an empirical approach, and the authors could not offer a consistent explanation.

I tried this once on a patient who refused to take "no" for an answer. The first day he wore them he fell down the stairs. I have never had the courage to order this again.

For the patient with poor vision in the unoperated eye, tinted plastic temporary cataract glasses are usually acceptable. Many patients are so happy with them that they use them as spares.

Acceptance of spectacle correction in monocular aphakia is more likely to occur if the dominant eye is corrected. When the non-dominant eye is operated on first, aphakic correction of the operated eye and blur of the dominant eye by a balance lens causes a vague malaise. Similarly, correction of an aphakic eye by a contact lens is more likely to be well accepted in the dominant eye.

If the non-dominant eye is corrected, it may be necessary to wear an occluder over the balance lens for comfort. The occluder for the balance lens may be helpful in the patient who insists on having the second eye operated on because he believes this will ease his adjustment to cataract glasses, which at the moment are intolerable. The question here is, does the patient's unhappiness stem from the aphakic correction, or because of retinal rivalry with the unoperated eye? Unless his complaints are greatly reduced by an occluder over the balance lens, we must conclude that operation of the second eye may render him an optical cripple.

At each postoperative visit, it is well to take the patient's vision with his approximate correction plus a pinhole. If the patient develops some complication which blurs the vision, we are alerted; meanwhile the patient has had prior demonstration that the operation was initially successful.

I usually refract the patient at six weeks, and repeat it weekly. When no change occurs, glasses may be ordered. Unless the operated eye can read at least two lines more than the unoperated eye, a prescription for glasses is unwise. I once saw a patient who could be corrected to 20/50 in the operated eye and 20/70 in the unoperated eye. He had been refused glasses at the V.A. and he pestered me for days until, after voluminous warnings of the side effects of aphakic glasses, I gave in

and ordered glasses. From the day he received his glasses, he haunted and deviled me until finally I bought the glasses from him, and sent him on his way. It was worth it. To this day, these glasses sit in a cabinet in my office, and when a patient nags me for an unwarranted aphakic correction, I excuse myself, go to the back room and take this memento out of the cabinet, gaze at it thoughtfully, and return to the examining room with hardened resolve.

If the patient has clear media and a regular astigmatism, retinoscopy serves well for objective testing. The best results come with use of a trial frame, with about 10 degrees of pantoscopic tilt, adjusted so the lens barely clears the lashes. Many of the poor results in aphakic refraction were obtained by using a phoropter. The lens should be well centered and the patient should be told to keep his head straight.

If retinoscopy is unsatisfactory, refraction can be done by the primitive method, or by the Keratometer if there is no irregular astigmatism.

In the primitive method, the best possible vision is obtained by varying the sphere. Then a cross cylinder,  $-0.50 +1.00$ , is rotated in the trial frame to find the principal axes of the astigmatism. Trials are then made with additional cross cylinders, flipped in the principal axes, incorporating their power into the trial frame as visual acuity improves.

The major portion of the astigmatism in aphakia is generated by the anterior surface of the cornea, so that measurement of the curvature of this surface gives an excellent clue to the proper cylinder to order. Nadelbath<sup>3</sup> gives a simple formula for changing the value of the astigmatism measured on the corneal surface to the correct cylinder for fitting at a vertex distance of 14 mm. If the spherical correction is about  $+10.00$  D, his formula comes out to a 25 per cent reduction in power of the cylinder to compensate for its greater effective power at a vertex distance of 14 mm. The amount by which the cylinder

should be reduced is figured from the formula:

$$\frac{\text{approximate spherical power}}{14} \times \frac{\text{astigmatism at corneal surface}}{3}$$

Classically, we have been told that we should record the vertex distance as part of our prescription, with the expectation that the optician will take account of this and alter the strength of the lens if he has to change the vertex distance. In practice, I have never seen an optician do this. Sloane<sup>4</sup> says that we should measure the vertex distance of the present glasses and match this with the trial frame. Two mm. should be added for the thickness of the lid.

Fonda<sup>5</sup> has said that he was appalled to discover that, although he had carefully included the vertex distance in his prescriptions for many years, opticians had paid little attention to it, but simply fitted the lenses to barely clear the lashes. This is excellent practice, for, as Benton and Welsh<sup>1</sup> have pointed out, it improves the appearance by cutting down on the unsightly condensation of light on the patient's eyes, reduces the strain on convergence in binocular aphakia and enlarges the visual field. The larger field results because the closer the lens to the eye, the farther out in the periphery is the ring scotoma.

Benton and Welsh<sup>1</sup> have also pointed out that magnification is increased by steeper front curves and thicker lenses. This follows from the formula for magnification:

$$M = \frac{1}{1 - tD_1}$$

Magnification in aphakia occurs in two ways: shape magnification and power magnification. Shape magnification results because the aphakic lens itself is a miniature telescope, in which  $D_1$  is the front surface and  $t$  is the thickness of the lens. Power magnification, as we have already seen, results from the plus

lens out in front of the eye in which minus power has been created by extraction of the crystalline lens. The total magnification is the product of shape magnification  $\times$  power magnification.

If for some reason we must recalculate the effective power of a lens when its vertex distance is changed, the simple formula  $\Delta = SD^2$  is accurate enough for clinical purposes.

$$\begin{aligned} \Delta &= \text{the change in effective power} \\ S &= \text{the shift in meters} \\ D &= \text{the dioptric power of the lens} \end{aligned}$$

Thus a five mm. shift in a +10 lens changes the power by 0.005 meters  $\times$  10 squared or 0.50 diopters. If the cylinder is not too large it can be left unchanged. In large astigmatic errors, however, the cylinder changes also. A cross tree should be constructed diagramming the power in each principal axis, and the change in each axis is then calculated separately.

For example, in the prescription +10.00 +5.00 axis 180, the power in the vertical meridian is +15.00 and the power in the horizontal meridian is +10.00. Suppose the vertex distance is to be changed from 15 mm to 10 mm. A stronger lens will be needed. Each meridian is calculated separately.

$$\begin{aligned} \text{Vertical Meridian, +15.00 D} \\ \Delta &= SD^2 \\ &= 0.005 \times 225 \\ &= 1.125 \text{ D} \end{aligned}$$

$$\begin{aligned} \text{Horizontal Meridian, +10.00 D.} \\ \Delta &= SD^2 \\ &= 0.005 \times 100 \\ &= 0.50 \text{ D} \end{aligned}$$

The power in the vertical meridian must be increased by one diopter while the power in the horizontal meridian need be increased by only 0.50 diopter. Moving the lens in 5 mm., the new prescription should read +10.50 sph. +5.50 cyl. axis 180, since the new power in the vertical meridian must be +16.00, while the new power in the horizontal meridian must be +10.50.

When ordering glasses for the unilateral aphake never order a balance lens without



specifying its exact power. Otherwise, the optician may use a scrap or spare lens with a cylinder in it. It costs no more to specify a +10 or +11 sphere. A year or two later, when the second eye has been operated on, refraction of this eye is simplified. One can use a phoropter over the balance lens for retinoscopy and subjective refraction, and simply add +10 to the result. The optician is told to use the same frame, and no allowance for vertex distance is necessary.

The Halberg trial clip, made by Keeler, is a useful aid in refracting over the present aphakic correction. Benton and Welsh<sup>1</sup> have pointed out that one can do a refraction with it, over the old lens, even if the old lens contains a cylinder. When the best vision has been obtained with a sphere and cylinder over the old sphere and cylinder, the whole combination is placed in a Lensometer and the reading is used as the new prescription. No allowance for vertex distance is necessary.

Bilateral aphakia eliminates the problems resulting from unequal image size but creates new problems. Patients who have been monocular for any significant time may develop phoria or tropia. When several years separate the operations on the two eyes, the patient is more likely to suffer diplopia. This diplopia often subsides, sometimes because of suppression, and other times by an apparent decrease in the angle of squint. If it is intractable, occlusion of one eye may become necessary.

Not infrequently, the patient suffers in his attempt to use both eyes because of faulty centering of the lenses. When the first eye is fitted, it is wise to ask the optician to decenter the bifocal at least 3 mm. in anticipation of the second operation and refraction. Because of the strength of the lenses, small faults in alignment of the lenses may cause vertical or horizontal phorias and rejection of the glasses.

The stronger the aphakic lenses, the more difficulties we may expect in their fitting. Benton and Welsh<sup>1</sup> have classified the powers of aphakic lenses as follows:

*Very Weak Prescription* (below +9.50.) These patients have the fewest complaints. They should not be given lenticular lenses and may be given a wider selection of frames. They are the only aphakic patients who can successfully wear trifocals, provided they have had round pupil surgery.

*Weak Aphakic Prescriptions* (+9.50 to +11.50). These patients complain of poor side vision but not as much as in the stronger prescriptions. Again, a lenticular lens is not necessary in this group. Bifocal segments may be two mm. below the optical center of the distance lens, either as a flat top or large round top segment. Especially with wide anatomical p.d.'s the burden on convergence may be large, and can be reduced by additional decentration of the bifocal segments and reduction of the strength of the bifocals in binocular cases. Plastic or zyle frames should be avoided as they tend to increase the ring scotoma. Contact lenses are helpful.

*Medium Aphakic Prescription* (+11.75 to +13.50.) This group comprises over 75 per cent of all aphakic cases. Weight becomes a real problem, and Benton and Welsh<sup>1</sup> advise their minimal effective diameter lenses to minimize lens weight. An alternative is the use of plastic lenses, which, however, may lack the cosmetic advantage of optimally designed glass lenses.

Especially in round pupils, flat top segments, 1 or 2 mm. below the distance optical center, are indicated. It is desirable to place the bifocal close to the distance optical center in order to avoid the aberrations that increase toward the periphery of strong lenses. In binocular cases, the burden on convergence must be minimized by every possible means, including weaker bifocal adds, very close vertex distance, large decentration of segments, and care not to use an optical p.d. wider than the anatomical p.d. Contact lenses are helpful.

*Strong Aphakic Prescription* (+13.75 to +15.25.) In this range, the problems of aphakia become major: the lenses are heavy, distortion is great, and in binocular cases the

strain on convergence may become insuperable. Round pupils are desirable to facilitate fitting with contact lenses. Flat top segments just below the distance optical center, and reduced in power to  $+1.75$  to  $+2.25$  should be used.

*Very Strong Aphakic Corrections* (over  $+15.75$ .) All the previously mentioned difficulties become crippling in this group. Surgery in patients with high hyperopia should be postponed as long as possible. Because of the extreme weight these patients do better with aspheric lenticular plastic lenses. The vertex distance should be as short as possible and bifocal additions should be kept as weak as possible. If the distance lenses can be decentered in, this will help the patient maintain binocular vision for near.

In my own practice, aspheric plastic lenses have been well accepted by most aphakic patients. The wider visual field and decreased weight seem to mean more to patients than their cosmetic disadvantage.

Bentol and Welsh<sup>1</sup> have rendered a tremen-

dous service to the profession by producing their book on spectacles for aphakia. We should all read it and reread it.

In summary, no matter how elegant our surgical technic the operation of cataract extraction may prove an abysmal failure if we lack the knowledge and desire to sidestep the pitfalls that beset the correction of aphakia. Each step, from the decision to operate, the choice of procedure, the post-operative care, and the optical correction, must be made in full consideration of the problems peculiar to this group of patients.

### Bibliography

1. Benton, Curtis J., Jr. and Welsh, Robert: *Spectacles for Aphakia*. Springfield, Illinois, Charles C. Thomas Company, 1966
2. Lubkin, A., Stollerman, B., and Linksz, C.: *American Journal of Ophthalmology*, 61:273 (February 1966)
3. Nadbath, D.: *Archives of Ophthalmology*, 60:534 (October 1958)
4. Sloane, Albert E.: *A Manual of Refraction*. Boston, Little, Brown, 1970
5. Fonda, Gerald E.: *Refraction Problems*. Rochester, Minnesota, American Academy of Ophthalmology, 1971

5723 Park Avenue

### Higher Pay for Military Physicians

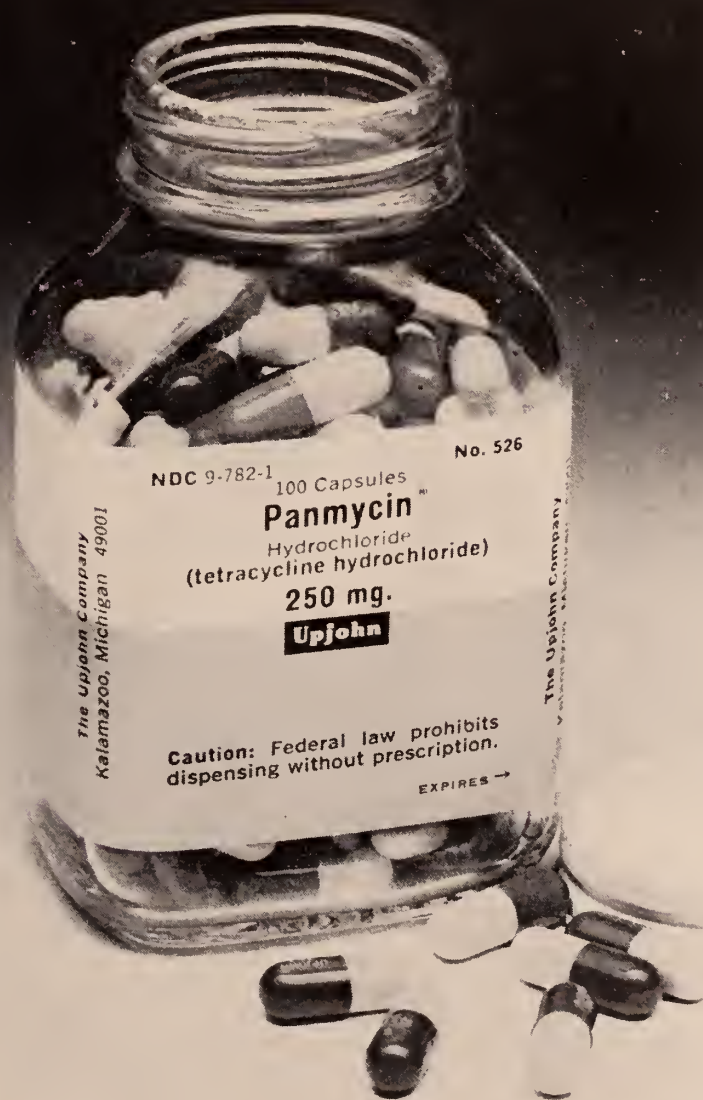
In the hope of retaining and attracting sufficient numbers of physicians in the armed forces without resorting to a continuation of the physicians' draft, the Administration offered Congress a special pay program under which military physicians could earn above \$40,000 a year. Under the plan, the military services are authorized to give physicians as much as \$17,000 a year in extra pay. This would be on top of \$350 a month above the base pay for their rank, after two years of service.

The bill also continues the special pay provision now in effect (but that would expire when the draft ends) of \$100 a month addi-

tional for the first two years of service. At present, the \$100 a month is increased to \$350 a month in steps after two years of service. However, the bill speeds the process up by inaugurating the \$350 monthly special pay immediately after two years. The \$17,000 continuation pay is a maximum and most physicians would not receive this much. Thus after two years, a military physician could earn at most the salary of his rank, plus \$350 a month, plus \$17,000 a year.

The bill also provides that public health service commissioned corps officers could receive up to four months additional pay per year over their military rank salary for signing up.

# Upjohn's low-priced tetracycline



## Panmycin<sup>®</sup>

(tetracycline HCl, Upjohn)

Available as 250 mg capsules and  
tetracycline syrup 125 mg/5 ml

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY





*"Your dinner was perfect—from soup to 'Dicarbosil'."*



**Dicarbosil®**  
ANTACID

Write for Clinical Samples

**ARCH LABORATORIES**

319 South Fourth Street, St. Louis, Missouri 63102

## Pre-Sate®

### (chlorphentermine HCl)

**CAUTION:** Federal law prohibits dispensing without prescription.

**Indications:** Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e., several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

**Contraindications:** Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monoamine oxidase inhibitors, since hypertensive crises may result.

**Warnings:** When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

**Drug Dependence:** Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

**Usage in Pregnancy:** The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

**Usage in Children:** Not recommended for use in children under 12 years of age.

**Precautions:** In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

**Adverse Reactions:** **Central Nervous System:** When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

**Dosage and Administration:** The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

**Overdosage: Manifestations:** Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

**Management:** Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

**How Supplied:** Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information available on request.



**WARNER-CHILCOTT**

Division, Warner-Lambert Company  
Morris Plains, New Jersey 07950

# for the practical generation **Pre-Sate<sup>®</sup>** (chlorphentermine HCl)

the trend is  
toward our kind  
of anorectic

**Not a controlled drug under the Comprehensive  
Drug Abuse Prevention and Control Act**

- low potential for abuse
- less CNS stimulation than with d-amphetamine  
or phenmetrazine

**Effective anorectic adjunct to your program  
of caloric restriction and diet re-education**

- weight loss comparable to d-amphetamine and  
phenmetrazine, superior to placebo
- convenient one-a-day dosage







**Pink isn't exactly his color,  
but he loves it for a change.**

**WinGel<sup>®</sup>**

aluminum-magnesium hydroxides  
mint-flavored antacid liquid and tablets

For your ulcer and ulcer-prone patients...  
a refreshing break from the  
boring sameness of white antacids.

- pleasing mint flavor
- non-gritty texture
- formulated to avoid  
constipation and laxation



**Winthrop**

WINTHROP LABORATORIES  
NEW YORK, N.Y. 10016



*Because polycystic disease of the liver is uncommon, it may be missed.*

# Polycystic Liver Disease in Two Sisters\*

**Stephen M. Levine, M.D., et al.  
Camden**

Polycystic liver disease is an uncommon problem in clinical medicine. Its significance lies in its benign nature and good prognosis in spite of signs of hepatic enlargement. The greatly enlarged liver felt on physical examination and multiple filling defects seen on isotopic scanning are in striking contrast to the general healthy appearance of the patient and her normal liver function tests.

We are reporting two sisters with polycystic liver disease. In the first patient, a fourteen year follow-up affirms the relatively good prognosis usually observed, and in the second case suspected recurrent metastatic malignancy led to liver biopsy, abdominal exploration, and ultimately the true diagnosis. Neither sister was aware that her sibling had polycystic liver disease.

## Case One

A forty-one year old female was admitted to The Cooper Hospital on August 12, 1957, for the first time with the chief complaint of right flank pain, nausea, and vomiting for two weeks. She had been in good health all of her life until a year before admission, when she noted sub-sternal fullness and weakness, occurring an hour after her meals.

In 1956 she had been admitted to another hospital with the diagnosis of hepatitis and/or cirrhosis. The symptoms that precipitated that admission were similar to those in 1957. No records are available from the other hospital, but there was no history to suggest either post hepatic or alcoholic cirrhosis. Past medical history and family history were unremarkable as was her review of systems.

The patient appeared well developed and in good health. Examination was entirely normal except for a large right upper quadrant lobulated mass, thought to be the liver.

Laboratory data included a normal hemoglobin, white blood count, urea nitrogen, sugar, albumin, cholesterol, bilirubin, and urinalysis. Chest examination was within normal limits. Intravenous pyelogram revealed normal-sized kidneys with no evidence of polycystic disease. The inferior liver margin was quite low and extended below the iliac crest. Sigmoidoscopy, barium enema, and upper gastrointestinal series were all normal.

Because of the markedly enlarged liver, an exploratory laparotomy was done. Many small and large cysts covered both lobes of the liver. The kidneys were of normal size. A biopsy was taken from the right lobe of the liver and the abdomen closed.

The pathological specimen included a 2 by 1.7 by 1 centimeter piece of liver which was nodular and contained many cysts; the largest was about one centimeter wide. Microscopically, many cysts lined with flattened epithelial cells were present. An occasional bile duct showed some cystic dilatation. There was no inflammatory reaction about the liver parenchyma. The patient was discharged on September 3, 1957, feeling very much better.

Her second admission, in 1962, was for "dyspepsia." Physical examination again revealed an enlarged liver and all laboratory data, including liver function tests, gallbladder series, upper gastrointestinal x-rays, and chest x-ray were normal. With bed rest and antacids the patient was discharged from the hospital improved.

In February of 1971, she was readmitted with the complaint of abdominal fullness and urinary frequency. Physical findings were unremarkable except for the persistence of an enlarged lobular liver. Routine laboratory data including a complete blood count, serum calcium, phosphorus, SGOT, and bilirubin were all within normal limits, as were the glucose, urea nitrogen, albumin, alkaline phosphatase, and cholesterol. BSP showed 7 per cent retention after forty-five minutes. Urinalysis revealed microscopic hematuria, but intravenous pyelography demonstrated normal appearing kidneys. The microscopic hematuria was due to a urethral stricture. Liver scan

\* This study is from the Departments of Medicine and Surgery at The Cooper Hospital in Camden, New Jersey, and the Jefferson Medical College in Philadelphia. Coauthors are F. Peguero-Olivo, M.D., N. Musulin, M.D., E. Principato, M.D., B. Liepa, M.D., and L. Principato, M.D. The authors wish to thank Mrs. Marie Thompson of The Reuben Sharp Medical Library, The Cooper Hospital, and Mrs. Iris Ulzheimer of The Cooper Hospital for their assistance.



Figure 1—Liver scan of case one showing enlarged liver with multiple filling defects in both lobes.

demonstrated enlargement with irregular uptake, particularly within the left lobe of the liver. (Figure 1).

On routine sigmoidoscopy a small adenomatous polyp was found and resected, and on microscopic sectioning was found benign.

In the past fourteen years since the diagnosis of polycystic disease of the liver was made, she has had no major problems or complications although she states that if she overworks she gets abdominal fullness. Relief is obtained through bed rest.

## Case Two

A sixty-year old sister of the first patient was admitted to The Cooper Hospital for the sixth time during the summer of 1971 for a liver biopsy. She was unaware of her sister's diagnosis of polycystic liver disease. In April, 1971, she underwent a right radical mastectomy for an infiltrating duct cell carcinoma of the breast. At surgery metastatic disease was found in three out of twenty lymph nodes. In April no hepatomegaly was noted on physical examination, and laboratory data were completely normal.

Previously she had been admitted for paroxysmal atrial tachycardia as well as a total abdominal hysterectomy for a fibroid uterus. In 1965 she underwent abdominal exploration for colonic polyps. The liver was not abnormally large, either on physical examination or at the time of surgery. The adenomatous polyp removed showed carcinoma *in situ*. In 1967 she had exploration for lysis of adhesions; once again, no mention is made of an enlarged liver.

Soon after the patient's mastectomy, she began experiencing some abdominal fullness and a "dragging sensation." She saw her local physician who palpated a very enlarged liver for the first time, and she was admitted to the hospital for a liver biopsy to rule out

metastatic tumor. She was well nourished and appeared in excellent health. Examination was normal except for the amputated right breast and a very large lobular liver which extended six finger breaths below the right costal margin and three finger breaths below the left costal margin.

The following laboratory data were within normal limits; a complete blood count, serology, serum calcium, phosphorus, glucose, BUN, creatinine, and LDH. Liver function tests included a normal alkaline phosphatase, SGOT, albumin, globulin, and cholesterol. The bilirubin was 0.4 mgs. per cent. Radiographic examination of the lumbar spine showed osteo-arthritis changes but no suggestion of metastatic disease. Intravenous pyelogram was normal.

In August 1971, a percutaneous liver biopsy was attempted. Seventy milliliters of a straw-colored fluid were aspirated from the liver. The fluid had a pH of 8.2 and contained 17.4 units of amylase and no lipase. Cell count revealed 32 RBC's, 13 polys, and 2 lymphs. A liver scan had been performed and showed uneven distribution of the isotope throughout the liver. There were several zones of decreased uptake in the right lobe and a large zone of no uptake at the inferior medial aspect of the left lobe. The changes were consistent with metastatic or polycystic liver disease (Figure 2).

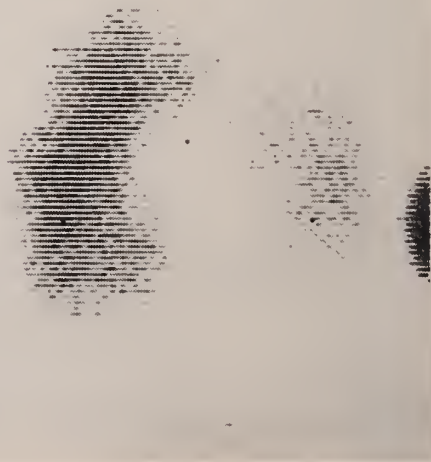


Figure 2—Liver scan of case two showing enlarged liver with several areas of decreased uptake and a large zone of no uptake at the inferior medial aspect of the left lobe.

At laparotomy the liver showed grape-like cysts which involved the entire left lobe. The right lobe revealed a similar, but less extensive process. A partial resection of the left lobe of the liver was performed. (Figures 3 and 4).

The pathological specimen showed numerous cystic structures within the liver measuring from .3 centimeters to 2.5 centimeters in diameter. Histologically the cysts were lined by cuboidal epithelium.



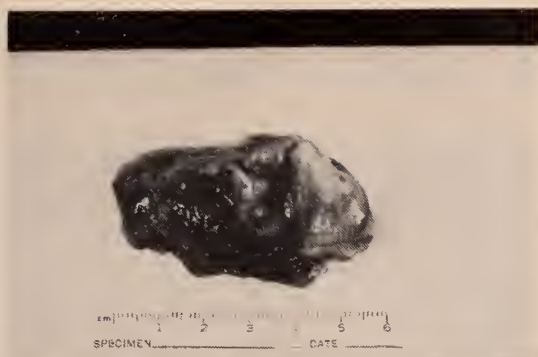


Figure 3—Resected specimen of case two showing polycystic liver.



Figure 4—Resected specimen of liver transected to show numerous cysts in case two.

The patient was discharged feeling well and assured that her liver was cystic but free of tumor. Her surgeons then related to her that they had another patient with a similar problem and found out that these women were sisters.

### Comment

Our two patients illustrate many typical findings in polycystic liver disease. Polycystic disease of the liver is more common in women than in men. Haschemian and James<sup>1</sup> described two women with multiple cysts of the liver and cite a female to male ratio of 4 to 1. Comfort<sup>2</sup> reported a 5 to 1 ratio, female to male, among 24 patients in his review of the Mayo Clinic experience with polycystic livers. In a recent review of over 117 cases of non-parasitic cysts of the liver, Peltokallio<sup>3</sup> reported a female to male ratio of 4 to 1.

These cysts are thought to be congenital in origin, but the problem does not become apparent until the patient is between forty and sixty years of age. There appears to be an inherited incidence of polycystic liver disease.

Among the 117 patients described by Peltokallio,<sup>3</sup> 29 had one or more relatives in the same series. Elliot<sup>4</sup> also suggested an hereditary factor in this disease.

Since patients with polycystic liver disease often have no symptoms, diagnosis is incidentally made at laparotomy or at autopsy.

As in our two patients, polycystic liver disease may give rise to mild symptoms. Abdominal distention and fullness, fatigue, a dull intermittent "dragging sensation," punctuated by several episodes of acute pain in the right upper quadrant, as well as a palpable mass may direct the patient to the physician. On examination the clinician is struck by the general good health of the patient while a large lobulated mass is easily felt in the right upper quadrant. The greatly enlarged liver suggests metastatic liver disease but without other findings that corroborate carcinomatosis. Liver function tests, like most of the physical examination, are distinctly normal as compared to the physical finding of an enlarged liver.

X-ray examination of the abdomen may show a greatly enlarged hepatic shadow. Rarely, annular calcifications may delineate some of the cysts. This finding was present in seven of the 117 patients in the series reported by Peltokallio.<sup>3</sup> Displacement of the stomach and colon is often seen on upper gastrointestinal series and barium enema, but these findings are fairly non-specific and indicate what was already known on the physical examination. Intravenous pyelography is often useful in demonstrating the presence or absence of polycystic renal disease, an accompanying finding in 30 to 90 per cent of the cases. Although neither of our patients had polycystic kidney disease, both had adenomatous polyps of the colon.

One of the most useful and innocuous diagnostic procedures is the liver scan. On this examination numerous-sized filling defects may be observed which in the presence of normal liver function tests should suggest the diagnosis of polycystic liver disease. Percu-



taneous liver biopsy and aspiration of the cystic contents will also help verify the diagnosis. Peritoneoscopy and ultrasound scanning have also been proposed as methods of diagnosing this unusual problem. (Comfort,<sup>4</sup> Niemetz<sup>5</sup>).

The course of polycystic liver disease is relatively benign. Occasionally a patient will develop symptoms which may require surgical treatment. Our two patients had good symptomatic relief with respective drainage and excision of the larger cysts. Resection of the cysts has been performed by some surgeons with good results. It is possible that with simple aspiration, the cysts may eventually re-expand. Life expectancy does not appear to be shortened although an occasional patient has developed complications. Campbell<sup>6</sup> reported three siblings with bleeding esophageal varices. These patients had in addition to cysts in the liver, polycystic kidneys, and were under 25 years of age. Others<sup>7-10</sup> have reported bleeding from varices, and those patients were relatively young. Other rare complications include enteric fistulization and cholangitis. Feldman and Jemerir<sup>7</sup> presented two cases of polycystic disease of the liver with spontaneous rupture and hemorrhage of the cysts.

The cysts as in our patients vary from a few millimeters to several centimeters. Histologically the cyst is lined by cuboidal cells which resembles the epithelium of bile ducts (Figures 5 and 6). In about ten per cent of the cysts no epithelium may be seen. In these cases the atrophic epithelial lining is probably secondary to pressure exerted by the fluid within the cysts.

### Summary

Polycystic disease is an uncommon, but usually uncomplicated disease of liver presenting in women for the first time during middle age. The diagnosis is suggested by a greatly enlarged liver attended by multiple filling defects on liver scan, symptoms of mild pain and tenderness in the right upper quadrant

without abnormalities of liver function; treatment is symptomatic. Surgery is reserved for the symptomatic or complicated cases.

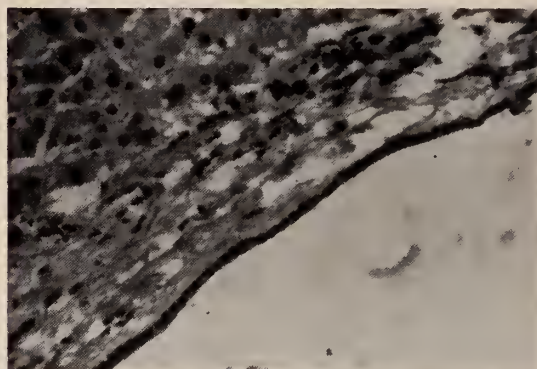


Figure 5—High power (x 400) view of cuboidal cell living cysts in case two.



Figure 6—Low power (x 100) view of cysts of liver in case two.

### Bibliography

1. Hashemian, H. and James, T. G. I.: *Brit. J. Surg.*, 42:405 (January 1955)
2. Comfort, M. W., Gray, H. K., Dahlin, D. C. and Whitesell, Jr., F. B.: *Gastroenterology*, 20:60 (January 1952)
3. Peltokallio, P., Taskinen, P. J. and Peltokallio, V.: *American Journal of Roentgenology*, 101:543 (November 1967)
4. Elliot, J. F.: *Canad. M.A.J.*, 66:164 (February 1952)
5. Niemetz, D., Sokol, A. and Meister, L.: *Annals of Internal Medicine*, 31:319 (August 1949)
6. Campbell, G. S., et al.: *New England Journal of Medicine*, 259:904 (November 1958)
7. Sedacca, C., Perrin, E., Martin, L., Schiff, L.: *Gastroenterology*, 40:128 (January 1961)
8. Gaisford, W. and Bloor, K.: *Proc. Roy. Soc. Med.*, 61:18 (March 1968)
9. Boros, E. and Fink, J.: *New York State Journal of Medicine*, (September 1952)
10. Sabeh, C. and Edwards, G. A.: *Archives of Internal Medicine*, 111:226 (February 1963)
11. Feldman, M. and Jemerin, E. E.: *Journal of Mount Sinai Hospital*, 32:666 (December 1965)

The Cooper Hospital

*Lithium seems to have established itself as a useful drug for manic episodes. Many practitioners question its value in depression. The Fair Oaks experience, however, shows a high rate of effectiveness even in depressive episodes.*

# Lithium in Treatment and Prevention of Affective Disorders\*

**Granville L. Jones, M.D. and Sergio D. Estrada, M.D./Summit**

In the summer of 1968 authorization was received for the investigational use of lithium carbonate in the treatment and prophylaxis of affective disorders in Fair Oaks Hospital. The study was carried on until the spring of 1970, at which time we were notified that lithium carbonate had been released for general medical availability. The patients who were receiving lithium, either for treatment or prevention, were continued for the most part as indicated, but the present report does not attempt to follow up past April 1970.

Thirty-eight patients were studied. This included those suffering from any of the affective disorders, including psychotic depressive reaction, schizo-affective schizophrenia, involutional melancholia, depressive neurosis, and cyclothymic personality as well as manic-depressive illness. Most were manic-depressive illness, about equally divided between depressions and excitements.

Schizophrenia, schizo-affective	4
Involutional melancholia	1
Manic-depressive illness, manic type	13
Manic-depressive illness, depressed type	8
Manic-depressive illness, circular and mixed	9
Psychotic depressive reaction	1
Depressive neurosis	1
Cyclothymic personality	1

The ages of these patients ranged from 17 to 76.

Below 20	3
20-29	6
30-39	5
40-49	6
50-59	10
60-69	6
70-up	2

Nine patients were single, twenty-one were married, five widowed, and three divorced.

All the subjects were private patients of the participating staff doctors. The principal criteria used were: (1) a diagnosis of an affective type disorder, (2) willingness of the patient and the responsible relatives to accept treatment with an investigational drug; (3) failure to respond satisfactorily on this or previous occasions to more conservative treatment. Some patients were, in effect, self-selected, coming with a request for the new drug which they had heard about in the press or on the radio. Some were referred by psychiatrists in the community specifically for the use of lithium. Lacking any properly matched control group, it was decided to use individual patients as their own controls. This was found to be reasonably feasible as far as the preventive aspect was concerned. The immediate effect as a treating technic had to be judged largely on the basis of the clinical impression of the treating psychiatrist, the observations of the family and/or the impression of the patient.

\* From Fair Oaks Hospital, Summit, New Jersey



Thirty-one patients gave a history of previous attacks; seven were apparently suffering their first episode. Twenty were continuing on the drug at the time of the termination of the study. Eighteen had had the lithium discontinued.

Of the eighteen patients in whom the drug was discontinued, ten patients did not cooperate. Four suffered undesirable side effects. One was discontinued because of poor results and one patient died. (The death was not related to lithium.) In two cases, lithium was discontinued by the referring physicians for what they considered were good medical reasons.

Eighteen patients were depressed when lithium therapy was begun. Of these there were ten in whom the immediate response appeared to be good. In one it was judged to be fair only, and in seven the result was deemed poor.

In sixteen cases the presenting symptom was excitement. In fourteen the immediate response was considered good. In one it was fair, and in one it was poor. Four patients were in a state of remission when lithium was started. Obviously in these an immediate response was neither sought nor could it be observed. Lithium was given for the purpose of prophylaxis. In the sixteen cases in whom the presenting symptom was excitement, the long term results were considered good in seven, with no recurrence, and in one the result was considered fair, with demonstrable episodes. In eight cases, results were considered poor (rehospitalized) or the drug was discontinued.

In eighteen patients in whom the presenting symptom was depression, the results on the long term were good in nine in that there was no significant recurrence. In five patients, results were poor, meaning that the patient had to be hospitalized or had clinical recurrence. The drug was discontinued in three—in one because of adverse effects, one did not cooperate; and in one by his community doc-

tor. The patient who died was also in the depressed group.

In the four patients who were in a remission when the drug was started, the results were good in two and it was discontinued in two.

While it may appear that lithium is a more effective preventive against depression than it is against mania, it should be kept in mind that some of our patients discontinued the drug when they were apparently starting in a period of elation. Patients in this phase of their illness tend to be lacking in insight. They usually describe themselves as feeling normal or very good and are well known for stopping medication for the reason that they feel they need no treatment. On the other hand, depressed patients or those going into depression do have an understanding that they are sick and are more willing to cooperate in treatment or prevention.

None of the four who developed adverse side effects was very ill, and in all of them the symptoms subsided promptly when the drug was stopped.

### Case Reports

A 64 year-old woman had been discharged from in-patient care. She was taking 1200 milligrams of lithium carbonate daily in the hospital with no side effects. Blood level had been around 0.5 to 0.7 mEq. At home, she developed nausea, vomiting, thick speech, and incoherence. She was also receiving Mellaril® and Elavil®. Lithium was discontinued and she was returned to the hospital promptly. Blood lithium was checked at 0.9 mEq. On admission, she had a fever which turned out to be the prodromal stage of an upper respiratory infection. Lithium was resumed later and the patient tolerated it well. It was finally discontinued because of failure to improve.

A 76-year-old woman was started on lithium carbonate, 1200 milligrams daily, on January 29, 1969. A blood lithium on February 3 was reported at 1.1 mEq. Dosage was then reduced to 900 milligrams. She soon developed tremors, muscle jerking, and incoordination. Lithium was then discontinued. The patient was also taking other drugs, including butaperazine, protriptyline, and benztropine, in moderate dosages.

A 25 year-old woman developed a tremor and an elevated protein-bound iodine after taking lithium for nearly a year. Lithium was stopped as a precautionary measure although blood lithium was never above 0.6 mEq. Thyroid function returned to normal. She is still in a remission.

A 43 year-old woman suffered recurrent depressions. She was not responding to convulsive shock therapy



and lithium carbonate was initiated on March 9, 1969. She developed nausea, vomiting and "burning in the stomach." Although her blood lithium was 0.3 mEq., the lithium was discontinued as a precaution and the patient was transferred to a public hospital.

A 71 year-old woman was considered a successful case, in short range and long range aspects. She had been admitted to Fair Oaks Hospital seven times in ten years with both depressions and manias. She started lithium on October 18, 1968, while on outpatient status. It appeared that the patient was still in a moderate depression although she had been released from the hospital a short time before. She was inactive, had no interest in social contacts and did little or no housework. The patient has tolerated the lithium well. Dosage has ranged from 600 a day to a maximum of 1200 milligrams. Her depression cleared promptly. She explained, "I don't feel drowsy, I don't feel slowed down, I don't have dryness of the mouth like I have with other medication. Lithium lets me feel normal." The patient has continued on lithium. She has had several mild episodes of dejection and several periods of overactivity but has continued to function well as far as her housework and social activities have been concerned. There have been no observable side effects. The patient has experienced the death of a sister, a moderately severe illness of her husband, visits by relatives, and other stressful events.

A 40 year-old man had a history going back to 1954. He has had several periods of depression which have resulted in losing a number of jobs. His marriage was showing signs of strain. He began lithium on October 17, 1968. He tolerated the lithium well and had no side effects. His domestic relationship improved promptly. He obtained a job, has worked at it consistently and recently reported that he expected to be a prize winner in a sales contest. On two occasions he reported that he was having a little difficulty awakening in the morning. This responded to temporary increase in the lithium dosage.

A 61 year-old salesman was admitted because of a manic episode of several weeks' duration. He started lithium on November 6, 1969, and responded promptly. All other medication was promptly discontinued. His mania subsided and he was making a good hospital adjustment when it was discovered that he had a large renal calculus. At a general hospital the stone

was removed surgically. The patient continued on lithium and was free of overt psychiatric symptoms while there. He has now been discharged from the care of the urologist and has obtained a new job in which he is quite effective. He has tolerated the lithium well. His blood level remains quite stable and he has had no adverse side effects.

A 54 year-old woman came with a depression. She was diagnosed as manic-depressive, circular. She has a history of affective episodes going back to 1954. She started lithium on February 18, 1969. Symptoms abated promptly. She has continued on the lithium, has had no side effects, and is still in a good state of remission.

## Summary

We present a study in which over 50 per cent of patients with affective disorders have continued on lithium with good results and with no adverse side effects. One patient in the group died, but the cause of death was not drug related. Four of the 38 were discontinued because of side effects. It is noted that in some of these, side effects were observed despite blood levels in the range usually considered safe and effective. A number of patients voluntarily discontinued largely because of lack of insight which led them to assume that they no longer needed any medication. Others were discontinued because of side effects or because the physicians who assumed clinical responsibility chose to use another type of treatment. It appears that lithium is effective in both manic and depressive conditions, and it seems quite effective in preventing recurrences of sufficient magnitude to require hospital admission.

19 Prospect Street

## New Diabetes Pamphlets

Announcement is made of the availability of revised pamphlets on diabetes. One is called *Diabetes and the School Child* and is written for parents, explaining the disease in understandable terms, without talking down to the reader. The other is a revision of the well-known brochure, *The Nurse and Diabetes Control*. Both are publications of the State

Department of Health. Single copies are available from the Division of Community Health Services, P.O. Box 1540, Trenton, New Jersey 08625. Also, a good deal of diabetes information (including suggested diets) will be found in the manuscript of *Diabetes Tapes by Phone*, available from the State Department of Health.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

## APATHY • IRRITABILITY FORGETFULNESS • CONFUSION



# Cerebro- Nicin<sup>®</sup> CAPSULES

**A GENTLE CEREBRAL  
STIMULANT & VASODILATOR  
FOR GERIATRIC PATIENTS**

**CEREBRO-NICIN<sup>®</sup> double-blind study\***  
shows how some senile symptoms can be treated.  
Four times as many aging patients showed  
striking improvement.

Each CEREBRO-NICIN capsule contains:  
Pentylentetrazole .....100 mg. • Nicotinic Acid ...100 mg.  
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.  
L-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.  
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.  
AVAILABLE: Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.

**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

**CONTRAINDICATIONS:** Epilepsy or low convulsive threshold.  
**CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .

**BROWN THE BROWN PHARMACEUTICAL CO.**  
2500 W. 6th St., Los Angeles, Calif. 90057

\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.O. & Franklin I. Shuman, M.O.  
Double-blind study on the treatment of mentally confused patients. Reprinted  
from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.



vacation in  
a vial:  
the spasm  
reactors  
in your practice  
deserve



# *“the Donnatal® Effect”*

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	( $\frac{1}{4}$ gr.) 16.2 mg.	( $\frac{1}{2}$ gr.) 32.4 mg.	( $\frac{3}{4}$ gr.) 48.6 mg.
(warning: may be habit forming)			

**Brief summary.** Side effects: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. Contraindicated in patients with acute glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.



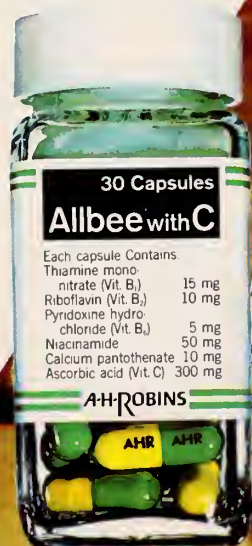
# 2 ways to provide a daily therapeutic supply of Vitamin C: 15 baked potatoes (skins and all!) or one capsule of Allbee® with C

About 20 mg. Vitamin C in one baked potato (2½" diameter).

To many people the evening meal just isn't complete without potatoes. But your patient would have to eat 15 of them (skins and all!) to get as much Vitamin C as is contained in just one Allbee with C capsule taken daily. A bottle of 30 (month's therapeutic dose) supplies as much ascorbic acid as 450 potatoes, plus full therapeutic amounts of the B-complex vitamins. For the patient who is counting calories, Allbee with C is small potatoes because the B's and C are water soluble. Consider the number of calories in 15 potatoes, not to mention the mountain of butter and sour cream. Allbee with C is available at pharmacies in the handy bottle of 30 and the economy size of 100 on your prescription or recommendation.

A. H. Robins Company,  
Richmond, Va. 23220

**AH-ROBINS**



# Disodium Cromoglycate\*

## A New Drug for Prevention of Bronchial Asthma

---

**Michael S. Mattikow, M.D./Wayne**

Some time this year a new drug called disodium cromoglycate will probably receive FDA approval and be released for clinical use in this country. The drug—produced by Syntex Laboratory under the trade name of Aarane and by Fisons under the trade name of Intal—offers a new approach to the treatment of bronchial asthma.<sup>1</sup> This drug was first synthesized in 1965 in Great Britain, and has, for four years, been used clinically in 80 countries, including England, Mexico, and Canada.<sup>2</sup> Therefore, a large body of clinical data has been obtained.

This is *not* a drug to treat an attack of asthma once it has started.<sup>3</sup> It is useful only *before* the onset of an attack, and must be considered for the prevention of asthma and not a substitute for present drugs. The drug is thought to work by preventing the release of mediator substances, i.e., histamine, slow-reacting substance, and so on. These are released from mast cells by antigen-antibody (IGE) reactions. It is the pharmacologic properties of these mediator substances that cause the changes seen in bronchial asthma.<sup>5</sup> Because of this, it was first thought that the drug would work only in IGE mediated or allergic extrinsic asthma. Further work showed that although best results were obtained in the younger individual with extrinsic allergic asthma without complicating bronchitis, it also worked to some degree in Type 3 asthma (immune complex), and it also seemed to prevent exercise-induced asthma. It was further shown that in many patients the use of bronchodilators and steroids could be remarkably lowered.<sup>2, 6</sup>

The drug may be helpful in the following situations:

1. Immediately before an unavoidable exposure to allergic substances. For example, a patient who likes to ride horses but who is allergic to them.
2. During a period of high pollen or mold exposure if the patient is sensitive to these allergens.
3. In a very labile patient who doesn't respond to the standard environmental and allergic methods of treatment.
4. It can be tried in the severe, chronic asthmatic of multiple etiology who is poorly controlled, except by the use of continuous steroids and bronchodilators. Unfortunately, in this type of patient results are not always impressive.<sup>7</sup>

We feel that this drug, in selective patients, will be quite useful. However, to quote Falliers<sup>8</sup> on disodium cromoglycate, "It seems doubtful that the most common form of asthma, the intermittent paroxysmal attack, related to occasional exposures to allergens or coinciding with infection, will require extended inhalation therapy with DSCG."<sup>8</sup>

The drug, a dry, odorless, and tasteless powder in a gelatin capsule with lactose as an inert propellant, is administered by inhalation in a special spin inhalator. The inhalator is activated by the patient on inhalation. A fan-like mechanism disturbs the powder and moves it from the capsule (which is punctured as it is placed in the inhalator). By taking three breaths the entire contents of one capsule enter the respiratory tract of the patient. No accumulation occurs anywhere in the body, including the lung. It is excreted rapidly *via* the urine and the bile, and has a

---

\* This paper was submitted on behalf of the New Jersey Allergy Society.



plasma half-life of only 90 minutes. For maximum effect, the drug must be used at least four times a day for the rest of the patient's life or on exposure to the specific allergens, since no desensitization occurs.<sup>9</sup> The exact cost of the treatment is not known yet. However, it will probably be between 10 and 25 cents per treatment (one capsule per treatment), and this must be considered in its use. Side effects are minimal.

Disodium cromoglycate is a new drug that has a different mechanism of action from other anti-asthmatic medications, and should prove to be a useful addition to the therapeutic modalities used by the physician in the treatment of the asthmatic patient. However, by no means is it a substitute for attempts to find and, if possible, avoid offending allergens.

Disodium cromoglycate is of no use in the treatment of an attack once it has started.

## References

1. Crepea, S.: personal communication (1972)
2. Pepys, J. and Frankland, A. N.: *Disodium Cromoglycate in Allergic Airways Disease*. London, Butterworth and Co., Ltd., 1970.
3. Pepys, J.: op. cit. (Ref. 2)
4. Altounyan, R. E. C., Orr, T. S. C., and Cox, J. S. G.: "Biological and Pharmacological Basis of Disodium Cromoglycate Therapy." Congress of Allergology, Florence, Italy, October 1970
5. Middleton, E.: In *Physiology and Pathology of Bronchial Asthma*. Boston, Little Brown, 1965
6. Pepys, J., Chan, M., Hargreaves, F. E., and McCarthy, D. S.: *Lancet*, 2:134 (1968)
7. Altounyan, R. E. C.: op. cit. (Ref. 4)
8. Falliers, C. J.: *J of Allergy*, 45:298 (1971)
9. Howell, J. B. and Altounyan, R. E. C.: *Lancet*, 2:539 (1967)

330 Ratzer Road

## Retrained Voice After Laryngectomy

Not everyone whose larynx has been removed in an operation for cancer need lose his voice. Two Toronto surgeons now report an operation in which a substitute voice box is built from living tissue after the cancerous, original larynx is removed.

J. Simon McGrail, M.D., and David L. Oldfield, M.D., of Toronto Medical School in Toronto, describe their operation in the August 1971 issue of *Transactions*, published by the American Academy of Ophthalmology and Otolaryngology.

The Canadians have done their one-stage operation on fifteen patients. "All the patients were able to talk four weeks following the operation and all had a good quality voice. This provided an immense psychologic boost," they said.

In most operations for cancer of the larynx, this section of the neck is removed and

the patient breaths through a hole in his neck. As a result, he learns to talk by controlling air burped up from the esophagus. Not all patients become proficient in learning such esophageal speech, however. There have been mechanical voice boxes, but, say Drs. McGrail and Oldfield, they have largely proved disappointing.

Previous surgical attempts to provide voice boxes of living tissue have required several operations. In the McGrail-Oldfield operation the cancerous larynx is removed and a new voice box fashioned at the same session. The surgeons take a strip of skin at the top of the patient's chest, and swing it over to the neck, where they fashion it into a tube that connects with the larynx below. Their patients still breathe through a hole in the neck, but a special breathing tube inserted there allows air into the windpipe when they inhale, and directs air up through the new voice box when they exhale.



# Heartburn

---

**Norman Riegel, M.D./Paramus\***

In the last several years, manometric pressure measurement in the esophagus has been perfected. Published data<sup>1, 2</sup> have revolutionized our understanding of heartburn.

Hiatus hernia (HH) is a common anatomic abnormality and has *nothing* to do with heartburn.<sup>1, 2</sup> Heartburn is caused by acidic gastroesophageal reflux. It occurs because of weakness of the lower esophageal sphincter zone (LESZ) and increased gastric pressure.<sup>1, 2</sup> LESZ pressure may be high, low, or normal, whether or not the patient has an HH. It is entirely unrelated to a hiatus hernia. Gastrin, the acid-stimulating hormone of the gastric antrum will increase the LESZ pressure. Antacids have the same effect because they raise intragastric pH, stimulating gastrin release from the antrum which, in turn, raises LESZ pressure. Antacids are rational therapy for heartburn because they prevent GER<sup>†</sup> and counteract peptic ulceration in esophagitis. Smoking abolishes the LESZ pressure explaining the common experience of heartburn associated with this habit.<sup>3</sup> Other drugs and hormones also have effects on LESZ pressure.

The physician evaluating a patient with chest pain needs a meticulous history, especially of the patient's response to antacids. GER<sup>†</sup> may be seen on x-ray, using fluoroscopy or cine, especially with increasing the patient's intra-abdominal pressure. Demonstrating HH does *not* indicate heartburn. At esophagoscopy one can see GER<sup>†</sup> and esophagitis and the latter can be documented by biopsy. Measuring esophageal pH is simple and very accurate in proving GER.<sup>†</sup> The best technic is manometry of the esophagus, which clearly identi-

fies most esophageal disorders. It directly records LESZ pressure—the technic is indispensable in a facility seriously interested in diseases of the esophagus. Many other tests of greater complexity and difficulty and less value abound in the literature; many are of only historical interest.

Despite the innovations in diagnostic methods and understanding of the pathophysiology of heartburn, treatment is surprisingly old-fashioned: antacids and common sense measures to prevent a rise in intra-abdominal pressure (no corsets), a drop in LESZ pressure (stop smoking), or GER<sup>†</sup> (sleep with pillow or blocks, sit up after meals). Anticholinergics are commonly prescribed for heartburn to reduce gastric acidity. Instead they markedly diminish gastric emptying and actually promote GER.<sup>†</sup> There is some evidence they also reduce LESZ pressure. They should *not* be used for heartburn due to GER.<sup>†</sup>

Prognosis is good. Most patients will prosper on treatment, symptoms will abate or disappear, and esophagitis will heal. However, they will *always* be susceptible to recurrence so treatment must continue for life. A few will not improve and these, along with the patients with severe complications (persistent bleeding, undilatable strictures, constant pain) must have surgery. There have been many operations for "hiatus hernia" repair each with enthusiastic supporters reporting excellent results.<sup>2</sup> I doubt *all* of these methods can be uniformly successful. Currently popular, fundoplication seems logical because it aims to create a new one-way valve (down) to prevent GE reflux.<sup>2</sup> Long-term results on

\*Dr. Riegel is Chief, Department of Gastroenterology, Bergen Pines County Hospital, Paramus, New Jersey.

†GER refers to gastroesophageal reflux.

large numbers of patients from several medical centers remain to be seen. There is no way to improve LES zone pressure medically or surgically.<sup>2</sup> For the high-risk patient, radiating his stomach to suppress gastric acidity has been successful in relieving symptoms and avoiding surgery. There have been side effects but there should be *none* with careful technic.

Briefly, all symptomatic patients should be

placed on the established medical regimen. A few with severe complications or persistent, severe symptoms will need surgery. Some of the later will improve with gastric radiation when surgery seems too risky.

### Bibliography

1. Cohen, S. and Harris, L. D.: *New Eng. J. Med.*, 284:1053 (1971)
2. Ingelfinger, F. J.: *New Eng. J. Med.*, 284:1095 (1971)
3. Dennish, G. W. and Castell, D. O.: *New Eng. J. Med.*, 284:1136 (1971)

Bergen Pines County Hospital

## Oral Hypoglycemic Drugs

The most recent labeling for the sulfonylurea drugs and for phenformin approved by the Food and Drug Administration provides that these drugs are indicated in the treatment of adult-onset non-ketotic diabetes mellitus only when the condition cannot be controlled adequately by diet and reduction of excess weight alone.

The labeling includes a special warning which says: Diet and reduction of excess weight are the foundations of initial therapy of diabetes mellitus. When the disease is adequately controlled by these measures, no hypoglycemic drug therapy is indicated. Because of the apparent increased cardiovascular hazard associated with oral hypoglycemic agents, they are indicated only when, in the judgment of the physician, insulin cannot be employed because of patient unwillingness, poor adherence to injection regimen, physical disabilities, such as poor vision and unsteady hands, insulin allergy, employment requirements, and other similar factors.

This labeling and regimen for diabetes mellitus are consistent with the therapeutic recommendations of the American Diabetes Association and the Council on Drugs of the American Medical Association, with which FDA

consulted on the evaluation of the University Group Diabetes Program (UGDP) study.

The long-term UGDP study suggested that the use of the sulfonylurea drug tolbutamide and the biguanide drug phenformin were associated with a greater incidence of cardiovascular mortality than diet alone, or than insulin plus diet.

Although the specific sulfonylurea drug studied by USDP was tolbutamide (Orinase®), the conclusions apply equally to all sulfonylureas—Diabinese®, Dymelon®, Orinase®, and Tolinase®, because of their close chemical relationship. Of the biguanides, only DBI-TD® was studied by UGDP, but the conclusions apply to DBI® and Meltrol® as well.

Further studies are being undertaken to shed additional light on the role of sulfonylureas and phenformin in the management of diabetes mellitus.

Because of increased cardiovascular hazard which appears to be associated with oral hypoglycemic agents, the drugs should be used only after full consideration of the special warning.

FDA Bulletin, May 1972.

*Here's one way of handling intractable pain, which usually brings about the desired results.*

# Depression and Intractable Pain Treated by Modified Prefrontal Lobotomy

**Arthur Winter, M.D./East Orange**

When physiologic and/or emotional pain becomes unresponsive to modern drugs and treatment, new methods must be considered. The modified prefrontal lobotomy performed with more precise technics (Figure 1) offers relief from both mental and physical pain.<sup>1, 2, 3, 6, 7, 8</sup>

The prefrontal lobotomies done in the late 1940's for psychiatric illnesses caused a remarkable change in the patient. The severely agitated or depressed patient became less agitated and depressed, but with dulled intellect. The reason was that the method was gross and used as a last resort. Today the lesion and size can be precisely located and titrated. The use of stereotaxis prefrontal lobotomy does not produce intellectual change nor gross brain damage.

The method is advocated because:

1. It reduces anxiety.
2. It reduces the need for narcotics and consequent drug addiction.
3. It reduces the patient's pain perception

although the memory of pain persists.

4. No or little change in intellect and discrimination ability. (Figure 4.)

A pneumoencephalogram is done to indicate the ventricular size. Single or bilateral burr holes are made behind the hairline and two centimeters lateral to the midline. The stereotaxic device is put into place and the probe guided to the prefrontal area (Figures 1, 2, 3). The initial lesion is designated at one centimeter above the orbital gyrus and one centimeter lateral to the midline. The thalamofrontal and frontothalamic fibers are intercepted. Using the HFG (high frequency generator) probe, a one centimeter lesion can be made precisely as located in the x-ray films. A plastic button is inserted over the burr hole. This is for cosmetic reasons and can easily be removed if the lesion has to be enlarged.

Sometimes we may not be able to cure our patients, but we can reduce their suffering and improve their quality of life (Table 1). Revised lobotomy has a place in medicine, particularly for patients with intractable pain due to cancer, mental depression, and drug addiction.

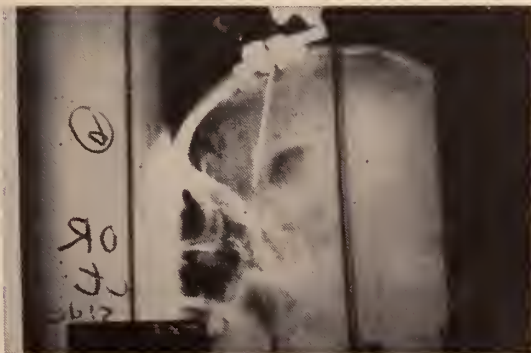


Figure 2—Lateral view with HFG probe anterior to lateral ventricle and above orbital gyrus.



Figure 3—AP view with HFG probe 1 centimeter from midline.



TABLE I  
Unilateral Pre-Frontal Lobotomy

Case	Age	Sex	Hospital	Diagnosis	Postoperative Medication	Results
1	81	M	OHM 9/20/63	Palsy. Lesion post pharynx eroding through skull (ca) Intractable pain Drug addiction	Darvon	Exp. in 2 mos. I
2	38	M	St. B. 1/23/69	Malignant melanoma Intractable pain Drug addiction	Darvon	Exp. 2/22/69 I
3	70	M	OMH 3/4/69	Carcinoma, left jaw Intractable pain	Darvon	Living I
4	33	M	St. B. 5/23/69	Schizophrenic reaction, paranoid type. Suicide attempt EST and psychotherapy	None	Living II
5	47	F	OMH 6/5/69	Carcinoma of uterus Intractable pain Depression Drug addiction	Demerol, 75 mgs. occasionally	Exp. 10/7/69 II
6	60	M	St. B. 10/2/69	Carcinomatous pelvic area Depression-suicide attempt Drug addiction Intractable pain	Steroids	Exp. 1/27/70 I
7	62	F	OMH 7/2/70	Multiple myeloma-severe pain. Platelet count = 9,000	Darvon	Exp. 7/17/70 I
8	70	M	OMH 11/18/70	Carcinoma of bowels with metastases-bowel, liver Sarcoma, intractable pain	Darvon	Exp. 11/20/70 I
9	66	M	OMH St. B. 2/4/71 S	Carcinoma bowel, liver-colostomy, 1969 Drug addiction Acute anxiety Intractable pain	Percodan	Living I
10	26	F	St. B. 3/2/71 S	Depressive reaction-suicide attempt	Stagc I	Living III
11	26	F	St. B. 3/12/71 S	Depressive reaction-suicide attempt	Ritalin Elavil Taractan Valium Noludar Dilantin	Living II
12	44	F	OHM 3/17/71	Psychoneurosis, severe Drug addiction	Dilantin Phenobarb	Living II
13	78	F	OMH 4/15/71 S	Mental Depression	Triavil Dilantin Symmetrel	Living II
14	56	F	St. B. 5/20/71 SB	Parapareses, L greater than R et: carcinomatosis Intractable pain-intrathecal saline Drug addiction	Percodan Elavil 5 mgm bid	Living II I
15	27	F	St. B. 2/3/72	Obsessive-compulsive suicidal-depression Idiopathic epilepsy since 1 year of age Temper tantrums	Dilantin 100 mgm bid Phenobarb 30 mgm bid Valium 5 mgm bid	Living I Not depressed, Cheerful, less frequent hand-washing, no temper tantrums, decrease in seizure-frequency.

Key: Grade In Results—I = Excellent, II = Good, III = Fair, IV = Poor, S = Stereotaxic, SB = Stereotaxic Bilateral

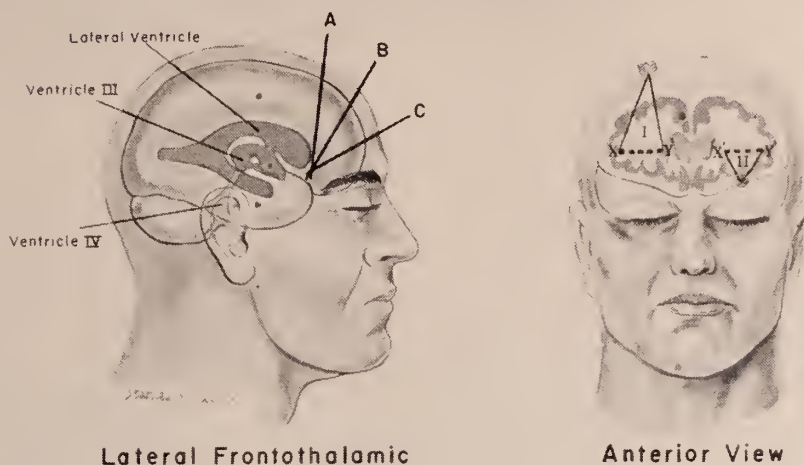
# PREFRONTAL LOBOTOMY - VARIATIONS

ORBITAL UNDERCUTTING

CINGULECTOMY

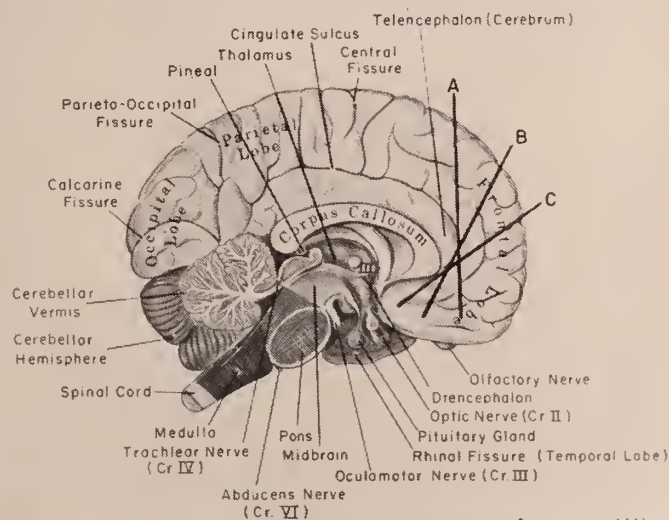
THALAMECTOMY, AMYGDALECTOMY

ELECTRODE IMPLANTS •



Lateral Frontothalamic

Anterior View



Arthur Winter, M.D.

Figure 1—Variations in electrode implant and prefrontal sites.

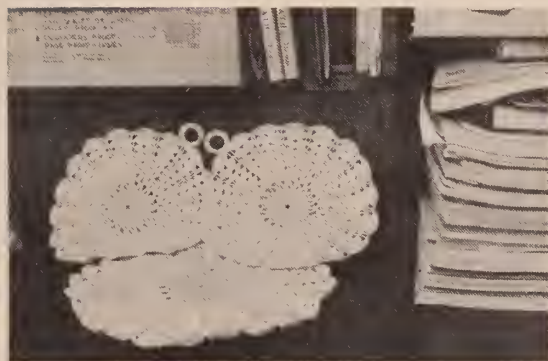


Figure 4—Note ability to knit postoperative. Refer to case #15.

## Bibliography

1. Grantham, E. G.: *J. of Neurosurgery*, 8:405 (1951)
2. Knight, Geoffrev: *Post Grad. Med. J.*, 45:1 (1969)
3. Lebeau, J. et al.: *Cashiers de Medicine*, 11:289 (1970)
4. Livingston, Kenneth: *Arch. Neurol.*, 20:20 (1969)
5. Shobe, Frank O. and Gildea, Margaret: *JAMA*, 206:2 (1968)
6. Thorpe, F. T.: *Journal of Mental Science*, 106:771 (1960)
7. Winter, Arthur: *Medical World News*, January 15, 1971, Pp. 34-43.
8. Winter, Arthur: *The Surgical Control of Behavior—A Symposium*. Charles C. Thomas, Springfield, Illinois, 1971.

The negative power of clinically significant anxiety  
in angina pectoris...



This man feels he is living  
on borrowed time.



During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

*Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,\* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)*

*Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.*

The positive power of  
adjunctive  
**Librium®**  
(chlordiazepoxide HCl)  
10-mg, 25-mg capsules  
up to 100 mg daily  
for moderate  
to severe anxiety  
accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido — all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

\*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Upjohn's low-priced erythromycin



**E-Mycin<sup>®</sup>**  
(erythromycin, Upjohn)  
Available in 250 mg tablets

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2141-6



*A harmless talcum powder can be a wry joke. As demonstrated here, talcum powder can be a mischief-producing substance.*

# Talcum Granuloma\*

**D. R. Patel, M.D. and  
Shigeo Kondo, M.D./Orange**

The word granuloma is derived from the Latin *granule*, i.e. granulation tissue. *Oma* means tumor. Rubber gloves in surgery need lubrication, both for sterilization and for ease in gloving. The clinical and experimental result of the talcum powder is severe adhesions, granuloma formation, or fistula formation.

Roberts<sup>4</sup> used a term to describe a granuloma from glove powder due to silicious particles and called the lesions pseudo-silicoticum. Through the years many descriptive words were added to the nomenclature, including talcum granuloma, pseudo-tuberculoma, pseudo-silicoticum, silicious granuloma, and starch powder granuloma. German<sup>2</sup> reviewed fifty cases of talcum granuloma following abdominal surgery and found granulomatous lesions in the omentum, peritoneum, and ovaries. Roberts<sup>4</sup> described five cases of talcum granuloma in the fallopian tubes, which led to sterility. Sahi, *et al.*<sup>5</sup> described two cases of fistula formation in the sigmoid colon as a result of talcum granuloma. Lalonde and Flieder<sup>3</sup> reviewed talcum granuloma at 18 different sites in six rabbits. They observed that talcum granuloma is due to biochemical reaction between tissues and talcum powder.

The appearance of eight documented, surgically and histologically proved cases of talcum granuloma, cyst, and adhesions formation prompted this report, with a review of the literature.

These patients had had previous surgery and none of them were diagnosed prior to surgery.

Of the five patients who had talcum granuloma after abdominal procedures, all had a smooth post-operative course for the first 2 to 6 weeks (See table).

One patient had an infected chronic ulcer of the face. Recurrent lactocele of the right breast was diagnosed in one case. One patient was diagnosed as a chronic abdominal wall abscess. Lipoma of the spermatic cord with a recurrent inguinal hernia was diagnosed in one case. Carcinoma of the head of the pancreas was diagnosed in one case because of jaundice and a mass in the right upper quadrant. Recurrent abdominal pain was a presenting symptom. Nausea and vomiting were present in four cases.

It is useful to document one case. This patient was clinically diagnosed as a carcinoma of the head of the pancreas.

A 63-year old female was admitted to the Hospital Center at Orange in June, 1969, because of severe abdominal pain in the right upper quadrant. The pain was worse after eating at any time, or any type of food, and associated with nausea and epigastric fullness. There was no fatty food intolerance and fever. There were no masses or organs palpable in the abdomen, except there was a sense of fullness in the epigastrium. Pelvic and rectal examinations were normal. The neck, heart, lungs and breasts were normal. Urinalysis showed 1+ albumin and was positive for bile. Alkaline phosphatase was normal. SGOT and SGPT were 21 and 17 units respectively. Cephalin flocculation was negative. The prothrombin time was 18 seconds with a control of 11. Total protein was 7.2 gm. per cent with 3.4 gms. per cent of albumin.

Past history revealed that she had appendectomy in 1924, cholecystectomy in 1939, right oophorectomy in 1944, and hysterectomy in 1946. She has had angina pectoris, atrial fibrillation, and hypertension and was treated by cardiac drugs. However, during this admission, the pain gradually increased and warranted

\* From the Departments of Surgery and Pathology of the Hospital Center at Orange (New Jersey), where Dr. Patel is senior resident in surgery and Dr. Kondo is attending pathologist.



exploratory laparotomy which was done on the fourth hospital day, with clinical impression of carcinoma of the head of the pancreas. This revealed multiple nodules and cyst formations, 8 to 10 in number, with 1 to 4 centimeters in diameter, on the anterior surface of the right lobe of the liver, and tissue biopsy was obtained.

Microscopically, the foreign body type granulomatous reaction is characterized by histiocytes with foamy cytoplasm, multinucleated foreign body giant cells, eosinophiles, neutrophils, and some lymphocytes. Talc granule crystals ranged from 5 to 17 micra in length, by 2 to 10 micra in width. Typical birefringent crystals were best seen under polarized light (Figures 1 and 2), and mostly found in the foreign body giant cells as well

as extracellular locations. This finding was present in all of the eight cases.

## Discussion

Talcum is composed mainly of hydrated magnesium silicate and initiates a very intense fibroblastic reaction which may give rise to dense adhesions within a few weeks; or the process may take years. Talcum powder is composed of 83 per cent talc (anhydrous magnesium silicate), 9 per cent calcium bicarbonate, 7 per cent magnesium carbonate, and 1 per cent zinc oxide. The talcum granuloma follows the spillage of talc into the operative field during surgery. In modern sur-

History of Eight Cases of Proved Talcum Granuloma Under Polarized Light

Patel et al

Case No.	Symptoms	Clinical Diagnosis	Past Operations	Present Operation	Findings	Remarks
1	Pain in RUQ Nausea, vomiting, jaundice.	Carcinoma of the Head of the Pancreas.	Appendectomy, 1924 Cholecystectomy, 1939 R. Oophorectomy, 1944 Total abdominal Hysterectomy, 1946	July, 1969	Multiple nodules and 8-10 cysts, 1-4 cm. diam. on Anterior surface of R. lobe of liver.	Biopsy of liver and adhesions.
2	Recurrent abdominal pain, nausea, vomiting.	Adhesions and Partial Intestinal obstruction.	Appendectomy, 1911 Caesarean Section, 1946 1948 R. Oophorectomy, 1958 Abdominal Hysterectomy, 1966 Incisional Herniorrhaphy, April, 1967	May, 1967	Multiple adhesions, nodules and tubercles over omentum.	Biopsy of adhesions.
3	Abdominal pain, nausea, vomiting	Adhesions and Intestinal Obstruction.	Cholecystectomy, Exploration of Common Bile duct. 1966	1967	Multiple adhesions.	Biopsy of omentum.
4	Abdominal pain, distention, nausea, vomiting.	Small intestinal obstruction.	Caesarean Sectn. 1940 " " 1942 Lysis of adhesions March, 1966	April, 1966	Adhesions and partial small bowel obstruction.	Biopsy of omentum and R. ovary.
5	Chronic ulcer on L. face.	Chronic non-specific ulcer.	Excision of ulcer, L. cheek. 1965	1967	Excision and biopsy.	
6	Pain and mass in R. breast.	Chronic abscess of R. breast.	Excision of lactocele, R. breast 1959, 1964	1965	Excision.	No abscess formation.
7	Abdominal pain and swelling, anterior abdominal wall.	Chronic Abdominal Wall Abscess.	Appendectomy, 1960	1969	Chronic mass, anterior abdominal wall. Excised.	No pus formation.
8	Swelling and pain in left inguinal region.	Lipoma of the Inguinal Region.	Left Inguinal Herniorrhaphy, 1965.	1970	Chronic mass, unrelated to cord, and superficial to external oblique muscle.	

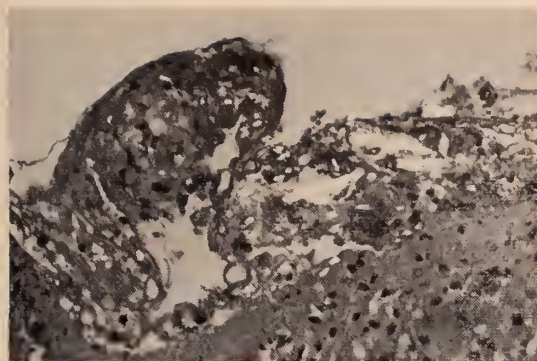


Figure I—Liver capsule, cyst and adhesions containing giant cell with doubly refractile crystals of talc under polarized light 400 x.

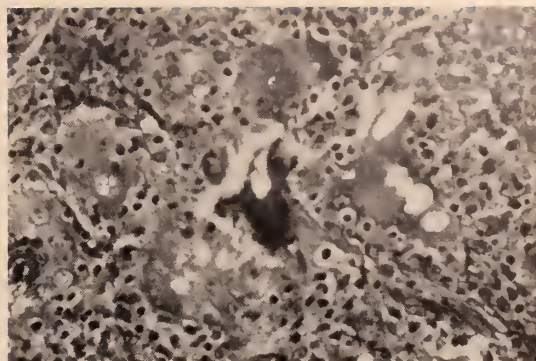


Figure II—Showing crystals with foreign body giant cell reaction under polarized light, 400 x.

gery, talc on surgical gloves is recognized as a hazard and has been abandoned.<sup>1</sup>

Surgeons should no longer rely on the simpler, quick, and much less effective method of rinsing the hand in the water-filled basin. Rubber gloves, tubes, drains, and so on must be washed or wiped off prior to surgery and care should be taken to avoid spillage should a glove be torn during surgery. Talc causes nodules to form on the peritoneum or any tissue in the body. These nodules or tubercles are found and may be mistaken for miliary tuberculosis or metastatic carcinoma. The causes of granulomatous reaction of the serous cavities and other tissues are talc, starch, lycopodium spores, mineral oil, and silica. There is simply no "ideal" glove powder at the present time.

It is important to wash off glove powder with two large sponges, rather than washing the glove in a basin which is inadequate to remove the powder. A torn or perforated glove should be replaced without delay.<sup>1, 4</sup> Certainly, less traumatic cases exist in every surgeon's experience; undoubtedly, many patients who complain of abdominal pain and tenderness 2 to 6 weeks after surgery may have had talcum granulomatous lesions which were unrecognized. Many so-called postoperative adhesions and infections are due to glove powder granuloma. The granulomatous reaction can happen in any tissue; however, in our case there were multiple cysts on the liver, which has not

been reported so far in the literature as a result of talcum granuloma. Any delayed pain, fever, mass, ulcer, or fistulae in a postoperative field should suggest the possibility of glove powder granuloma, and we strongly urge that the tissue slide be examined routinely under polarized light. Surgical exploration and perhaps excision of the mass is the only certain and hopeful way to prove the diagnosis and to resolve the pain and lesser symptoms. Once the diagnosis is established, the lesion may be left alone, or steroids might be helpful toward a speedy recovery. However, steroids were not used in any of these cases.

In the case presented here there was no correlation between the symptoms and the lesion, although the multiple cysts were found on the liver 30 years following cholecystectomy. The diagnosis was made in all cases on histopathological findings by using polarized light.

## Bibliography

1. Eiseman, B., Seelig, M. G. and Womack, N. A.: *Annals of Surgery*, 126:820 (1947)
2. German, W. M.: *Surg. Gynec. Obstet.*, 76:501 (1943)
3. Lalonde, E. R. and Fliedner, D. E.: *J. Oral Therapeutics and Pharmacology*, 4:104 (1967)
4. Roberts, A. B.: *British J. of Surgery*, 34:417 (1947)
5. Sahi, R. P., et al.: *J. Indian Medical Assn.*, 48:550 (1967)

188 South Essex Avenue

ALSO AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

**Android<sup>®</sup> 5** MUQETS  
BUCCAL Tabs

**Methyltestosterone N.F. - 5 mg.**

**Android<sup>®</sup> 10**

**Methyltestosterone N.F. - 10 mg.**

**Android<sup>®</sup> 25**

**Methyltestosterone N.F. - 25 mg.**

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosterone-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests as increased BSP retention and rises in SGOT levels, have been relieved after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating for symptoms of climacteric, avoid stimulation to the point of inducing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progressive bone metastases. • Sodium and water retention. • Priapism • Retention in female patients • Hypersensitivity and gynecomastia.

**DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized as patients vary widely in requirements. Daily requirements are administered in divided doses. The following chart is suggested average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40
Postpubertal cryptorchidism	30

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

**BROWN**

**THE BROWN PHARMACEUTICAL CO., INC.**  
2500 West 6th Street, Los Angeles, California 900



*The status and role of the physician in the newer organizations for distribution of medical care are here reviewed.*

# Survival of the Private Practice Concept in the Face of Prepaid Health Care\*

---

**Lee S. Goldsmith, M.D., LL.B./New York†**

Every company, organization, or association must keep some control over its costs and overhead. This has now been made to include medicine.

When medicine was the private province of the single practitioner costs were his concern and those of his patients. With the development of large hospitals, the delivery of health care began to involve administrators, nurses, paraprofessionals, and ancillary workers. Costs multiplied and the numbers of people employed also multiplied. The problems of payment, however, remained with the individual. If the individual had resources, care was obtained. If no resources were available, death was a not too uncommon result.

Physicians donated services to some and obtained payment from others. Institutions, however, with a relatively fixed overhead and not generally producing large profits, could not operate in a similar fashion. All patients had to be productive of some income so that money had to come from the patient or from some private source. With the management of the institutions came the individuals who were attempting to control costs, and initially this included the personnel and operating expenses, but not the costs for the actual delivery of medical care. These were separate entities.

With the development of insurance compan-

ies' paying the cost of not only the physicians' bills, but also the hospital expenses, a third party became concerned with the over-all costs. In order for the company to be profitable, the over-all costs had to be monitored. Therefore, there developed fee schedules which set forth the limits of the company's liability. However, the physician or hospital could charge in excess of the schedule and collect directly from the patient. This would then only be between the patient and the physician. The third party payer, therefore, could control the costs.

In the early 1940's the Kaiser-Permanente System was developed. Kaiser companies involved in the war effort found that they had large numbers of employees for whom medical care was necessary. The method of health-care delivery to such large groups necessitated building their own hospitals where none existed and obtaining the services of physicians who were not present locally. Instead of the population of physicians and patients growing gradually, physicians were hired to serve the patient and an over-all system of controls was developed. In one package, at no extra cost to the consumer, came medical and hospital services. The supplier of the services, Kaiser, had accurate figures with which to

---

\*Read before the Sections on Medicine, Cardiovascular Diseases, and Radiology, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 6, 1972.

†Dr. Goldsmith is special counsel to an association of physicians attached to several hospitals in New York City.

work and anticipate the income and overhead. The patient was also aware of the cost and that, depending on the particular plan, there would be no extras. Kaiser was an attempt to control all costs.

Whether Kaiser represents good medical care has been strongly debated, and I have strong questions in my own mind. However, financial problems and expenses are more important than the quality of care delivered, if the quantity is present and the patients satisfied. Kaiser-Permanente has grown since its inception.

### Medicare

With the growing needs of the poor and elderly for health care, and the growing costs of health care, the federal government entered the picture. Medicare did supply funds for the delivery of care. This enabled large numbers of people to obtain a degree of health care that they had never previously known. However, medicine did not supply the necessary manpower to meet the demand, thereby driving costs up. More individuals are receiving care, more care is being delivered, and, therefore, costs are greater. The supplier of the money was not controlling the cost, and, therefore, prepaid group plans similar to Kaiser-Permanente Plan have appeared to be very attractive.

So attractive is the concept of prepaid group practice that at one time there were as many as ten different bills before Congress. In 1972, a prepaid group practice bill was passed by the New York Legislature and signed into law by Governor Rockefeller. At this time it is impossible to state the final form of the federal bill. However, a preliminary review of the New York State statute will reveal some of the implications.

The New York bill permits insurance companies to contract with hospitals and doctors for the delivery of health care. Patients would subscribe with the company and receive a policy guaranteeing a certain amount of prepaid care. The company would generally own the hospital in which the care would be

delivered, and either employ the physician directly, or contract with private groups of physicians for supplying the care. Under certain provisions of the law, a medical corporation is established which would be the basis of the physician group. No physician member of the medical corporation could receive income in excess of 10 per cent of his income from outside of the corporation. That is, the physician would be effectively limiting his practice to that of the corporation, and could not establish outside relationships that would lead to the establishment of a private practice. The physician would be an employee of the corporation.

A second possibility would be the signing of a contract between a group of physicians and the hospital for supplying of care. There would then be no limit on outside income as long as the contracting physicians fulfilled their contract. Needless to say the medical corporation is the preferred form from the point of view of the hospital and insurance company as the physician-employees could be better regulated.

The implications are as follows:

Where an established institution suddenly becomes affiliated with a prepaid practice, the staff physicians will be given a choice as to whether they wish to affiliate. If they affiliate with the practice they would have to give up their private patients and begin treating only the group's patients. The group patients would not necessarily include their private patients, and the private patients might find it difficult to obtain medical care.

Affiliation with the practice would place the physician on salary and relieve him of all overhead. Limitations on income would be related to the contract with the hospital. The value of that contract appears to be directly related to the number of physicians available and willing to join a prepaid group practice. For example, Kaiser has given bonuses and incentive clauses in contracts to those physicians practicing in less desirable areas while

in metropolitan areas, such as San Francisco, a salary is generally all that is provided.

This difference is simply a manifestation of leverage, or bargaining power. If all the physicians on the staff of a hospital are desirous of joining the group, the terms of the contract may be dictated by the hospital. If the physicians have leverage, then better terms can be obtained. However, the physicians may lose their leverage once they become members of the group, and give up their private practice. Care must be observed to protect not only the present, but future relationships.

If the physician staff member decides that he does not wish to join the group practice, another problem may arise. The hospital may inform the physician that his privileges with the institution will be terminated at the conclusion of the year. Once a physician has lost his privileges, it may be difficult to obtain privileges in a neighboring hospital. During the period of time when he has no privileges the physician may not be able freely to practice medicine. It is yet to be determined as to whether hospital privileges under these circumstances is a right which can be protected by the courts.

With the outcome of any court test in question, it is obvious that, with federal and local governments pushing prepaid group practice, physicians and patients could be forced into undesirable situations. Certainly the number of physicians able to practice independently will be reduced.

The physician who finds prepaid group practice attractive will eventually find himself in a union striking for higher pay and benefits. He will be directed as to his work schedules, the number of patients he is to see, and the time in which he is to see the patients. The surroundings and equipment may be excel-

lent, the time for relaxation greater, and the pace slower.

For a period of time those physicians who wish to remain in private practice will find it difficult as the prepaid bandwagon will be very great. Large amounts of federal funds have already been made available to investigate the possibilities of establishing groups. Additional sums will undoubtedly be made available once the legislation is passed.

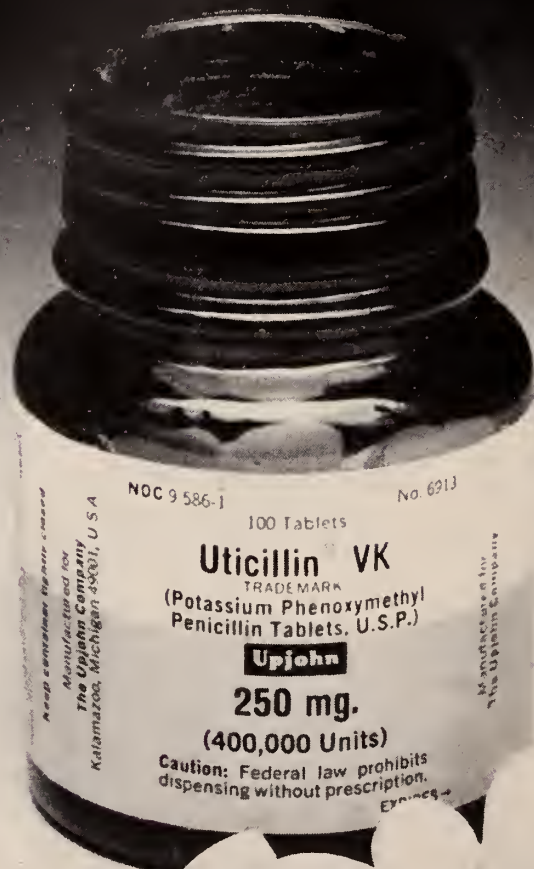
Prepaid group practices will develop initially in areas in which there are large population concentrations, where there are large unions and large masses of the poor. It has been in such areas where prepaid group practices have proved financially successful. However, it will be many years before the concept can be carried to the more rural areas effectively. There is little question that the prepaid group practices will grow. There is also little question that many physicians will voluntarily join prepaid group practices because of the benefits they believe to be present, and they may be correct in their opinions. However, I would make the following suggestions:

1. Evaluate the physician's role in any group being established.
2. Determine if the physician or the administrator controls how and when care is being delivered and whether or not there is a sound medical basis for these decisions.
3. Do not permit inadequate numbers of physicians to operate a prepaid group.
4. Do not cause private patients to be without medical care because a group is formed.
5. Do not permit physicians to lose staff privileges because a group is formed.
6. Insure that the calibre of patient care remains high, or that it is improved.

200 Park Avenue



# Upjohn's low-priced penicillin VK



## Uticillin<sup>®</sup> VK

(potassium phenoxymethyl penicillin, U.S.P., Upjohn)

Available in 250 and 500 mg tablets;  
250 mg/5 ml and 125 mg/5 ml flavored granules  
for oral suspension

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2144-6

## HALL-BROOKE FOUNDATION, INC.

A non-profit organization dedicated to community health care and education.

Elisabeth Solomon  
Executive Director

Albert M. Moss, M.D.  
Medical Director

### HALL-BROOKE HOSPITAL

A JCAH accredited hospital for care and treatment of psychiatric disorders within a therapeutic community.

Leo H. Berman, M.D.,  
Director of Professional Services

### HALL-BROOKE SCHOOL

A special educational facility for adolescents of high school age who are in psychiatric treatment.

Edgar J. Appelman,  
Director

47 Long Lots Road  
Westport, Connecticut 06880  
Telephone: (203) 227-1251

"Prescribe With Confidence"

K A T E S B R O S .

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

*Barefoot... Freedom*

---

SOLD ON Rx ONLY

CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN  
OUTFLAIR SHOES FOR CLUB FEET

---

400 MAIN STREET

HACKENSACK, N. J.

201-487-1779

Dennis Brown Splints — In all sizes — Carried in stock  
CUSTOM SHOE SHOP ON PREMISES

# YOU CAN MAKE A DIFFERENCE



Overcrowding, unemployment, discrimination and hunger contribute to mental illness. They also serve as barriers between the poor and proper diagnosis and effective treatment of mental illness.

The National Association for Mental Health is committed to tackling the problems of the disadvantaged, by helping them secure the benefits of advances in the prevention, diagnosis and treatment of health problems.

Your Mental Health Association is working to ensure that services for the mentally ill are provided in areas where they are needed the most.



## JOIN AND SUPPORT YOUR MENTAL HEALTH ASSOCIATION

*Citizens Who DO Make A Difference*



## Medical School's Board of Concerned Citizens

College of Medicine and Dentistry of New Jersey

The College of Medicine and Dentistry of New Jersey announces a new, modern approach to community relations. In January 1971, when its Board of Trustees was confronted with a series of community problems arising from the development of its 56-acre campus in Newark, it formed the Board of Concerned Citizens, a special advisory group which reports directly to the President and Trustees on all matters affecting the college employees and the community. This group was created because the community needed a communication vehicle with the college administration.

This advisory group, said Dr. Stanley Bergen, President of the College, "is unique not only because community leaders, faculty, college, and hospital staff gather to discuss the basis for our policies and actions, but also because the Board of Concerned Citizens has developed guidelines for its own involvement that have been agreed to and endorsed by both faculty and trustees of the college. I believe that this effort represents a first in the field of education."

John K. Kittredge, Chairman of the College's Board of Trustees, who worked to establish the advisory board, said, "traditionally the academic community has concentrated on teaching and research; community relations have been limited to alumni relations or fund-raising projects. However, particularly in this era of social change, we recognize the need for such an organization, and we have encouraged and aided in its development and totally endorse it and the guidelines published in its position paper."

The 16-member Board is appointed for a one-year term by the College's Board of Trustees. It chose as its first chairman Carroll M.

Leevy, M.D. Professor of Medicine and Chairman of the Faculty Organization at the New Jersey Medical School.

The position paper of the Board of Concerned Citizens states that its fundamental purpose is, "to work cooperatively with all other health workers and with communities within the Greater Newark area in a partnership which will enable the entire institution"—the College of Medicine and Dentistry of New Jersey-New Jersey Medical School and its primary teaching hospital, Martland Hospital—"to promote and protect health in its fullest sense."

Roland E. Stewart, Executive Director of the Business and Industrial Coordinating Council, serves as a member of the Board of Concerned Citizens. "Our purpose," he said, "is not to control the school, nor to create jobs for our friends. We intend to support and encourage the College's administration in its activities and decisions, as long as there is continuing evidence of a firm, fair, and even-handed application of universal human dignity to employees of the institution and to the community."

The Board will make recommendations to establish priorities and plans for future activities in the development of the College's Newark-based medical and dental complex. It will review and investigate suggestions and grievances of students, employees, faculty, and community and make recommendations. Also, this Board has the responsibility to review proposed fund allocations within the Newark complex and to advise President Bergen on such fiscal matters.

In terms of the community, the Board assists in judging the needs, quality, and/or termi-

nation of health care services provided by the college. Recruiting, interviewing, and reviewing candidates for staff and faculty for the New Jersey Medical School and its primary teaching hospital, Martland Hospital, has been one of their most active roles. They also inform new administrative employees of the special considerations and needs of the Newark community.

The advisory group plans to assist the College in developing appropriate recruitment programs for students in all of the College's professional areas. As the role of the College grows in providing health services and facilities, the Board of Concerned Citizens will broaden its functions and responsibilities to meet the need for their involvement.

Mr. Kittredge has explained the historical basis for the Board of Concerned Citizens. "In 1966," he said, "when plans were announced to locate the college in Newark, the city was celebrating its 300th anniversary. There were parades and concerts and very positive activities, but behind the scenes the frustrations and anxieties of Newark's black and Spanish-speaking citizens were festering.

"The following year," said Mr. Kittredge, "we had a riot that destroyed a portion of the city, further polarized the races, focused national attention on Newark, and brought forth a new leadership concerned with the large, disadvantaged minority population. We have worked closely with this leadership through organizations like the Greater Newark Urban Coalition, the Urban League of Essex County, the Anti-Defamation League of B'nai B'rith, and the Business and Industrial Coordinating Council to make the College aware of and responsive to community needs. However, we decided that the College needs a formal, structured, impartial group to help us identify problems and recommend solutions. The Board of Concerned Citizens meets many of these needs."

During the past year, as a result of its recommendations on college operations, steps have

been taken to improve employee conditions and community health programs. Employees of the college and especially Martland Hospital, generally feel that the situation is improving.

With input from the Board of Concerned Citizens, the College developed a grievance procedure that ensures that the problems of all levels of employees be heard impartially in the highest administrative circles. The Board has also made an impact on the College's decision to develop career-ladder training programs, which enable employees to progress to positions of greater responsibility. Its urging produced the development of a weekly newspaper to keep employees aware of developments throughout the entire College.

The Board has been particularly active in recommending measures to recruit, develop, and educate an increasing number of minority students in medicine and dentistry; as a result, the 1972 freshmen class at the New Jersey Medical School will have an increased proportion of minority students.

"The Board of Concerned Citizens," said Dr. Bergen, "has grown to be an extremely valuable resource for my administration. It encourages greater communication between the College and the community, and through it, we can feel the pulse of our staff, the student body, hospital employees, and the community that surrounds our complex, and we can identify problems before they grow too large and develop plans that are more relevant to the various publics we serve."

"In the beginning," Dr. Leevy stated, "it was the community that came to us seeking our attention to its needs, wants, and desires. Now, with the Board's assistance and counsel, we are able to understand better community and employee needs and take them into consideration in the development of plans, programs and projects."

Members of the Board of Concerned Citizens include: Bailus Walker, Jr., Director of the

Department of Health and Welfare, City of Newark; Roland E. Stewart, Executive Director of the Business and Industrial Coordinating Council; Earl Phillips, former Executive Director of the Urban League of Essex County; Robert C. Kohler, Regional Director of the Anti-Defamation League of B'nai B'rith; Herbert Holmes, M.D., representing the North Jersey Medical Society; Carroll M. Leevy, M.D., and Alfonse Cinotti, M.D., representing the New Jersey Medical School; Robert Thompson, D.D.S., representing the

New Jersey Dental School; Santo DiFino, a medical student, representing the student council; and from Martland Hospital, Paul Bolanowski, M.D., representing the house organization; Herman Carter, representing the social work staff; Mrs. Dorothy Crews, representing the registered nurses; Michael Flanagan, representing the housekeeping staff, Mrs. Audrey King and Mrs. Marion Ruffin, representing licensed practical nurses; and Mrs. Pat McReynolds, representing the family planning department.

### Commencement Speaker Forecasts Medical Revolution

"We are witnessing the end of the 40-year-old debate about how the costs of medical care should be handled," said David E. Rogers, M.D., President of the Robert Wood Johnson Foundation and commencement speaker at the 1972 College of Medicine and Dentistry of New Jersey—Rutgers Medical School—graduation.

"Just within the past few years," explained Doctor Rogers, "it has been agreed that medical care is too important to rely on an individual or a family's ability to pay for it. I believe that within the period of your own post-graduate training, some sort of universal entitlement or national system of financing medical care will be enacted."

He noted that we are now on "the verge of another revolution in medicine . . . much more difficult and complex" than the one that preceded it. "This one, I would term the organizational revolution in health care."

He posed nine concerns which summarize the worries that Americans have about medical and health care "as they now perceive it."

1. It is too expensive to get and becoming more so.
2. It is increasingly difficult to know where to go to get care, or hard to find it when you need it.

3. Medicine is becoming increasingly impersonal, technologically and non-people oriented.

4. The quality of medical care is highly variable and there are very few yardsticks to know whether you are getting good or bad care even when you can get it.

5. We've not paid enough attention to the special problems of the infant, the elderly, and the chronically ill.

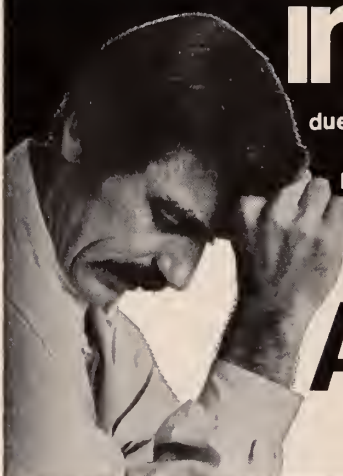
6. We are training too many specialists and not enough doctors who take continuing care of families or groups.

7. We've ignored health maintenance or preventive medicine or how to keep people well, leaving the impression that physicians are only interested in people who are mortally ill.

8. Our society is using after-the-fact remedies for many of its problems rather than approaching the fundamental causes which are actually not medical problems per se—killers like car accidents, alcoholism, drugs, smoking, child abuse, suicides, and the like.

9. We suffer by virtue of too many conflicting voices in matters of health and have failed to develop any rationally planned or articulated long-range policy for health affairs in this country.





The treatment of

# impotence


due to androgenic deficiency in the American male.

The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW  
CLINICAL  
STUDY

## Android<sup>®</sup>

(thyroid-androgen) tablets



**Double-Blind Study and Type of Patient:**  
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

**Choice of 4 strengths:**

**Android**

Each yellow tablet contains:

Methyl Testosterone . . . 2.5 mg.  
Thyroid Est. (1/6 gr.) . . . 10 mg.  
Glutamic Acid . . . . . 50 mg.  
Thiamine HCL . . . . . 10 mg.  
**Dose:** 1 tablet 3 times daily.

Available:  
Bottles of 100, 500, 1000.

**Android-HP**

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone . . . 5.0 mg.  
Thyroid Est. (1/2 gr.) . . . 30 mg.  
Glutamic Acid . . . . . 50 mg.  
Thiamine HCL . . . . . 10 mg.  
**Dose:** 1 tablet 3 times daily.

Available:  
Bottles of 100, 500, 1000.

**Android-X**

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone . . . 12.5 mg.  
Thyroid Est. (1 gr.) . . . 64 mg.  
Glutamic Acid . . . . . 50 mg.  
Thiamine HCL . . . . . 10 mg.  
**Dose:** 1 or 2 tablets daily.

Available:  
Bottles of 60, 500.

**Android-Plus**

WITH HIGH POTENCY  
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone . . . 2.5 mg.  
Thyroid Est. (1/6 gr.) . . . 15 mg.  
Ascorbic Acid (Vit. C) . . . 250 mg.  
Thiamine HCL . . . . . 25 mg.  
Glutamic Acid . . . . . 100 mg.  
Pyridoxine HCL . . . . . 5 mg.  
Niacinamide . . . . . 75 mg.  
Calcium Pantothenate . . 10 mg.  
Vitamin B12 . . . . . 2.5 mcg.  
Riboflavin . . . . . 5 mg.  
**Dose:** 2 tablets daily.

Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging of biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, lethargy, paraesthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Monteleone, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titali, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Melman, L., Bradlow, H. L., Zuzar, S., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypoheliotic effect of androstenedione. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Callan, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 75:863, 1956. 6. Biss, A., and Farar, E. E. United States Dispensary (ed. 25). Springfield, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057

---

# NEW JERSEY DOCTORS' NOTEBOOK

---

## Trustees' Minutes

July 16, 1972

A regular meeting of the Board of Trustees was held on July 16, 1972, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

*AMA Communications Clinic . . .* Authorized Mr. Edward F. Meara, III, Public Relations Counsel, to attend (with expenses paid) the AMA Communications Clinic, August 28 and 29 in Chicago.

*AMA Congress on Occupational Health . . .* Authorized a member of MSNJ's Committee on Occupational Health, Workmen's Compensation, and Rehabilitation to attend (with expenses paid) the Annual Congress on Occupational Health, September 11 and 12 in Chicago.

*AMA Air Pollution Medical Research Conference . . .* Authorized the Chairmen of MSNJ's Committee on Environmental Health to attend (with expenses paid) the AMA Air Pollution Medical Research Conference, October 2 and 3 in Chicago.

*AMA Conference on Continuing Medical Education . . .* Authorized the Chairman of MSNJ's Committee on Medical Education to attend (with expenses paid) the meeting of the Conference of State Medical Association Representatives on Continuing Medical Education, October 24 to 26 in Chicago.

*Council on Legislation . . .* Approved, as amended, the report of the Council on Legislation, including the contained recommendations.

### *Current State Legislation:*

All measures thus marked (\*) are identical with bills of last year—or preceding years—whose official positions were the same.

S-850 —To provide that the rules and regulations of the State Board of Education concerning school buses shall include requirements for school bus safety seats. *APPROVED*

S-851 —To provide that every school bus transporting children to and from school shall be equipped with emergency exits. *APPROVED*

S-852 —To require that every school bus transporting children to and from school shall be staffed with a monitor at least 16 years of age. *ACTION DEFERRED*, pending further statistical information from the Department of Education.

S-858 —To require health insurance to disclose, in clear and concise language, specified items about policies they are selling in order that the consumer may make an informed decision concerning his purchase of health insurance under the New Jersey Health Insurance Disclosure Act. *DISAPPROVED*, because while MSNJ approves the intent of the first portion of the bill to make policy language simple and clear, it is of the opinion that the bill goes too far and would only confuse the subscriber and impose unnecessary administrative burdens on the Commissioner of Insurance.

S-876 —To provide that leaves of absence shall be granted classified civil service employees for the purpose of donating blood. *APPROVED*

S-877 —To provide that leaves of absence shall be granted State employees for the purpose of donating blood. *APPROVED*

*Note:* The Board voted to change the recommended positions on S-876 and S-877 of "disapproved because MSNJ supports the voluntary donation of blood and to grant the donor a day off with pay is to expose him to the profit motivation that taints commercial blood-giving" to *APPROVED*.

S-878 —To provide that general public assistance shall be included in the current state-operated medicaid health care benefits program. *APPROVED*

S-889 —To provide that the medical assistance program shall include the cost of drugs prescribed for persons 65 years of age and older, not otherwise eligible for assistance, who are determined by the Commissioner of Health to need such financial assistance. *APPROVED*

S-890 —To provide immunity to volunteer fire and first-aid companies and rescue and emergency squads providing service for control of fires or emergency first aid and rescue services from civil liability to respond in damages. *APPROVED*

S-892 —To prohibit the sale of children's automobile seats which do not conform to the Federal Motor Vehicle Safety Standards for children's seats and harnesses and do not have affixed

- a date of manufacture label with instructions for proper installation. *APPROVED*
- S-893 —To provide for the care and treatment of alcoholism under the New Jersey Comprehensive Intoxication and Alcoholism Control Act; to create a Division of Alcoholism Control in the Department of Health and to appropriate \$1,500,000. *APPROVED*
- S-912 —To provide for regulation and licensing of persons engaged in a mail order drug distribution business. *APPROVED*
- S-919 —To provide that any applicant for renewal of a practical nursing license, originally granted by waiver, who can show 12 years of full-time experience shall be granted a license. *ACTION DEFERRED*, pending further information from the Licensed Practical Nurses Association and the New Jersey State Nurses Association.
- S-950 —To regulate the sale of patent medicines containing antihistamines, belladonna, alkaloids, phenobarbital or its salts, alcohol 5% or higher, ephedrine or its salts, caffeine of 35 milligrams per pill termed non-prescription drugs. *DISAPPROVED*, because this bill would increase their costs to the patient.
- S-965 —To provide that any person who hypnotizes or attempts to hypnotize another for any purpose including entertainment, except in the practice of medicine, is a disorderly person. *APPROVED*
- S-966 —To regulate the practice of dentistry. *DISAPPROVED*, because it would impose excessive powers in the Board of Dentistry and would enable them to set up broad and oppressively detailed bureaucratic regulations which would prohibit or unduly limit the licensed practitioner's right to exercise and be guided by his own best professional judgment.
- S-976 —To include under the act concerning sale or possession of hypodermic syringes, needles or instruments the use thereof adapted for the use of controlled dangerous substances. *APPROVED*
- S-977 —To provide that any person who possesses controlled dangerous substances for imminent use is a disorderly person. *APPROVED*
- S-980 —To define "qualified applicant" under the New Jersey Medical Assistance and Health Service Act to include in determinations of eligibility assistance under this program the chronic and recurring medical expenses of the family unit as a component of the standard of need. *APPROVED*
- S-997 —To provide that any person who sells, distributes, or dispenses morphine, cocaine, heroin, opium or any derivative thereof classified in Schedules I or II of the Controlled Dangerous Substances Act and who is not addicted thereto shall be guilty of a high misdemeanor and subject to a maximum imprisonment of 25 years without reduction of a sentence or eligibility for parole. *APPROVED*
- S-998 —To permit minors to consent to treatment and care by a hospital, public clinic or a physician when executed by a minor who is or believes he is suffering from drugs and to prohibit later disaffirmance. *APPROVED*
- S-999 —To provide that if the weight of alcohol in a defendant's blood is 0.07% or more, it shall be presumed that his ability to operate a motor vehicle was impaired. *DISAPPROVED*, because The Medical Society of New Jersey favors the criterion proposed in A-719.
- S-1000 —To provide that the State Commissioner of Health or a member of his staff designated by him shall be a member of the Clean Air Council. *APPROVED*
- S-1007 —To permit sending of handicapped pupils to privately operated day school instructional programs. *APPROVED*
- S-1037 —To require all State executive departments to establish and maintain comprehensive occupational safety and health programs. *APPROVED*
- S-1041 —To regulate the practice of ophthalmic dispensing. *ACTION DEFERRED*, until a copy of the bill is available.
- A-646 —To provide for allocation of \$.005 for each 10 cigarettes or fraction thereof for research into causes, prevention, and cure of diseases associated with smoking. *NO ACTION*
- A-647 —To increase the cigarette tax from 7 cents to 7.5 cents for each 10 cigarettes with the additional tax to be annually appropriated to the College of Medicine and Dentistry for research of causes, prevention, and cure of diseases associated with cigarette smoking. *NO ACTION*
- Note:* The Council recommended the position of *NO ACTION* on the above bills because a communication from the College of Medicine and Dentistry advised that, while it approved the general intent of these bills, it cannot take a position either for or against them as specific means of raising the needed revenues.
- A-836 —Requires every school bus to be staffed with a monitor at least 16 years of age in addition to the driver; effective at the commencement of the school year next succeeding enactment. *ACTION DEFERRED*, pending further statistical information from the Department of Education.
- A-961 —To provide for a mandatory seven day jail sentence for a first violation of the drunk driving statute and a mandatory 21 day sentence for a subsequent offense and to reduce the presumption measure of intoxication from 0.15 per cent to 0.12 per cent. *APPROVED*
- A-975 —To provide that when a local board of health adopts more stringent health or environmental protection ordinances or regulations than imposed by the Department of Environmental Protection it must obtain the approval of the Department. *APPROVED*



A-976 —To provide that the certificate of serological test required of couples applying for a marriage license shall indicate whether such couples are or are not positive carriers of sickle cell anemia. *DISAPPROVED*, because this legislation would impose an unjustifiable added "pre-marital" test on all that would be of use and significance to comparatively few, at a time when its effect would be minimal, since the test should be done in the period of pre-adolescence.

A-977 —To provide that treatment for drug abuse consented to by a minor shall not be subject to later disaffirmance and shall be reported only as required by the Controlled Dangerous Substances Registry Act. *APPROVED*

A-992 —To provide that all persons aged 65 or over employed as school crossing guards must undergo an annual physical and mental examination. *DISAPPROVED*

*Note:* The board voted to change the recommended position of "approved" to *DISAPPROVED* because the bill imposes an arbitrary discrimination solely on the basis of age.

A-1002—To establish a division of alcoholism in the Department of Health, to create an advisory council to provide for licensing of alcoholic treatment facilities, to prescribe procedures concerning arrest of an intoxicated person, to authorize establishment of a service force, and to repeal and prohibit municipal ordinances prescribing penalties for public intoxication. *APPROVED*

A-1008—To provide that the Commissioner of Health, with the advice of the committee, shall determine the total number of persons eligible for chronic renal disease care and treatment and shall include a sum necessary to carry out the provisions of this act in his annual budget. *APPROVED*

\*A-1019—To authorize the Commissioner of Environmental Protection to promulgate rules and regulations necessary to prevent the treatment and disposal within this State of solid waste collected outside this State. *APPROVED*

A-1024—To create the Genetic Disease Information and Prevention Act of 1972 in supplementation of the act concerning marriage. *DISAPPROVED*, because although MSNJ approves the intent of the bill, it is presently untimely, over-simplified, and impractical of implementation because of lack of competent personnel and facilities.

A-1027—To provide for licensing and regulating of pest control operators and to establish standards for fumigation under the New Jersey Pest Control Act. *APPROVED*.

A-1032—To provide that any person who denies medical treatment to an inmate of a correctional institution leading to the death of such inmate shall be guilty of murder in the first degree. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES*, because it would subject a person to the charge of murder on the basis of a simple human error of judgment.

A-1034—To require psychological testing of county and State correction officers as a condition of employment. *APPROVED*

A-1048—To prohibit manufacture, sale or distribution of recycled paper, cardboard or paper products intended for use as containers or wrappers for food products. *ACTION DEFERRED*, pending further information from the Department of Health concerning their thinking on this bill.

A-1053—To provide that acts of abortion by a licensed physician shall be justified within 20 weeks of commencement of the pregnancy where it is necessary to preserve life. *DISAPPROVED*, because the bill is at variance with the policy position taken by the House of Delegates in May, 1972.

A-1054—To provide that acts of abortion by a licensed physician shall be justified within 17 weeks of the commencement of pregnancy where it is necessary to preserve life. *DISAPPROVED*, because the bill is at variance with the policy position taken by the House of Delegates in May, 1972.

A-1055—To authorize the Commissioner of Environmental Protection to limit treatment and disposal within the State of solid waste collected outside of the State. *APPROVED*

A-1063—To increase the membership of the Advisory Council on Solid Waste Management from 11 to 13, including the Secretary of Agriculture and the Dean of the College of Agriculture and Environmental Services of Rutgers University. *APPROVED*

A-1095—To authorize the Commissioner of Education to contract with public and private agencies or clinics for experimental pre-school education programs for handicapped children. *APPROVED*

A-1097—To establish the Handicapped Children's Recreational Opportunities Act. *NO ACTION*

A-1103—To provide that on or after September 1, 1973 school buses shall be equipped with a speedometer, odometer, audible or visible signals to indicate excessive speed. *NO ACTION*

A-1111—To provide for the New Jersey Health Care Facilities Financing Authority Law. (Same as S-841 1972) *APPROVED*

A-1115—To provide that persons afflicted with tuberculosis shall not leave a hospital against the advice of the treating physician or until a release is signed by the treating physician. *APPROVED*

A-1121—To provide that any person, except a licensed physician, who uses hypnosis for clinical treatment to relieve a person from symptoms of illness or unwanted habits is a disorderly person. *APPROVED*

A-1132—To control and regulate the treatment and disposal within the State of solid and liquid waste collected outside the State and to authorize the Commissioner of Environ-

mental Protection to adopt rules and regulations. *APPROVED*

A-1133—To provide that any seller of age 18 and not addicted to the use of morphine, cocaine, heroin, opium or any derivative thereof shall, upon conviction, be punished by death. *NO ACTION*.

A-1134—To require that every bicycle frame, fender, front fork and other parts shall be treated with luminous paint to increase visibility when in use at night. *APPROVED*

A-1163—To authorize the State Board of Nursing to issue licenses for professional and practical nursing to former medical corpsmen of the United States armed forces who have successfully completed courses of instruction required to qualify for a rating of medical service technician. *APPROVED*

A-1168—To define "school" under the act concerning drug education to include grades kindergarten through 12th grade.—*APPROVED*

A-1179—To provide for licensing of audiologists and speech pathologists by the Board of Medical Examiners and to create an Examining Committee of Audiology and Speech Pathology.—*ACTION DEFERRED*, pending further information from the State Board of Medical Examiners and the New Jersey Academy of Ophthalmology and Otolaryngology as to their thinking on this bill.

A-1192—To permit the Director of Buildings and Construction, after consultation with the Director of the Rehabilitation Commission, to grant contracting authorities a waiver of any of the requirements imposed by the act to provide, in public buildings, facilities for the physically handicapped.—*DISAPPROVED*, because the Society has supported, as sound and desirable, legislation to provide facilities, in public buildings, for the physically handicapped. It maintains that position.

A-1195—To provide that regulations of the Board of Education concerning construction and equipment on buses shall include requirements for padding all metal bars on seat backs with energy-absorbing material. *APPROVED*

A-1198—To permit the county prosecutor to refer defendants, with their consent and who have not previously been convicted of any crime, to a program of supervisory treatment.—*APPROVED*

A-1202—To prohibit sale of baby foods containing monosodium glutamate and to provide that the rim of the cover of the container of baby food shall be completely enclosed in a metallic or plastic strip. *APPROVED*

A-1204—To permit taking of children into protective custody when the child has suffered physical injuries and the person suspected of inflicting is a person into whose custody the child would be normally returned. *APPROVED*

A-1251—Amends the Sales Tax to include certain professional services. *NO ACTION*

A-1293—To amend the "New Jersey Medical Assis-

tance and Health Services Act." *NO ACTION*

A-1295—Repeals the Unincorporated Business Tax Act. *APPROVED*

*Physicians' Assistants Program . . .* Authorized the mailing of a questionnaire to the membership "to inform and to solicit from MSNJ members information regarding the possible use of physicians' assistants." Representatives of the CMDNJ, both Newark and Rutgers, and the Livingston College of Rutgers University (who attended this meeting of the Board of Trustees) indicated that the physicians' assistants program is still in the planning stage; the initial class will enroll about 20 students; before implementation the program (which is based on one developed by Duke University and which will lead to a BS degree) will have approval of the medical school faculty, the CMDNJ Board of Trustees, the New Jersey Department of Higher Education, and the Board of Higher Education; preference will be given to applicants with previous health-related experience; and work is progressing to draft legislation to amend the Medical Practice Act to permit physicians' assistants to practice legally in New Jersey.

*Medical School in South Jersey . . .* Received a report from Stanley S. Bergen, Jr., M.D., President, CMDNJ, indicating that no definite plans have been made to establish a third medical school in South Jersey primarily because of the cost, that a feasibility study will be made to appraise the needs and population attitude, and that consideration is being given to utilizing the present schools for basic scientific training and then transferring students to existing South Jersey hospitals for their clinical training.

*Membership Opinion Survey—Resolution 26 . . .* Approved a report from the Council on Public Relations that in accordance with Resolution #26 meetings had been set up in each of the five Judicial Districts (the membership has been so notified and procedures outlined for those who desire to speak) with the members of the Judicial Council serving as coordinators; that as soon as possible after each meeting the coordinator will submit the

results to the Executive Director; and that subsequent to the compilation of the results of these hearings the Council will meet to decide on a questionnaire to be sent to all members, the results of which will be the basis for a report to the mandated special session of the House of Delegates.

*Public Relations Projects for 1972-1973 . . .*  
Approved the following continuing projects for 1972-1973:

1. Publication and distribution of (a) Junior Health Hints to schools and public libraries; (b) Membership Newsletter; and (c) Periodic Newsletter to co-operating agencies.
2. Preparation and publication of special news releases and publicity, including (a) Eye Health Screening Program; (b) Annual Meeting; (c) Child Safety Week; and (d) Selected official programs and activities.
3. Responsibility for bestowal of the Golden Merit Award.
4. Responsibility for the information center and issuance of press releases at the annual meeting.
5. Encouragement of orientation programs for new members under the sponsorship of component societies.
6. Encouragement of statewide emergency medical care coverage.

*Annual Meeting Information Center . . .*  
Approved a recommendation that Mr. Edward F. Meara, III, be re-engaged, on terms approved by the Board of Trustees, as Public Relations Council and encouraged to expand public relations activities with the Council's approval.

*Society-Sponsored Automobile Insurance . . .*  
Gave provisional approval to the following recommendation from the Committee on Medical Defense and Insurance, pending another meeting of the Committee to answer questions posed by the Chairman of the Committee:

That the Board of Trustees approve the establishment of a Society-sponsored Automobile Insurance Program by Aetna Life and Casualty Insurance Company to be offered to members of the MSNJ and that E. and W. Blanksteen Agency, Inc., be authorized to proceed with informing MSNJ members of the Group Automobile Insurance Program.

*Professional Liability Insurance . . .* Approved the following recommendations from the

Committee on Medical Defense and Insurance:

1. That the Board of Trustees approve amending Paragraph 7 of the Letter of Intent from Chubb & Son Inc. to read as follows:

"It is agreed that future rates shall be based on a permissible loss ratio (including all loss adjustment expenses—both allocated and unallocated) that equals unity less commissions, taxes, administrative expense and profit. The Company anticipates the permissible ratio will approximate 82.5 per cent."

2. That the premium rate for psychiatrists be reduced 10 per cent.
3. That the charge for shock therapy be reduced to one-half the charge for the practice of psychiatry.

4. That there be an additional charge equal to the appropriate premium in class one of practice for the neurologist performing such hazardous procedures as the angiogram, arteriogram, etc. All other premiums in various categories remain the same for the policy year beginning November 1, 1972.

*Medical Student Loan Fund . . .* Approved the following recommendations of the Committee on Medical Student Loan Fund:

1. That the Requirements for Participation be modified as indicated below, to be effective retroactively to June 1, 1970:

The last sentence of the first paragraph is revised to read . . .

"Interest of 6 per cent will be charged on the unpaid balance from the date of the borrower's entrance into medical practice, except that any borrower who enters upon medical practice in New Jersey will be charged interest at the rate of only 3 per cent per annum."

The third paragraph of Requirement #3 is deleted in its entirety.

2. That the check be made payable to the medical school and in the upper left corner the applicant's name be noted; that a letter accompanying the check be addressed to the Dean for referral to the appropriate school officer, and that the letter set forth the purpose of the loan.

3. That Legal Counsel be requested to look into the question of the tax status of contributions to the Medical Student Loan Fund.

*Woman's Auxiliary . . .* Approved, on recommendation of the Advisory Committee to the Woman's Auxiliary, the Auxiliary program for 1972-1973, which is essentially the same as that of the previous year.

*Volunteer Consultants in Prison Program . . .*  
Approved that action of the Executive Committee in indicating its willingness to cooper-



ate in a program outlined by Governor Cahill for the use of voluntary specialist consultants to give confirmatory opinions of certain abnormal conditions found among prison inmates at the time of physical examination.

*Joint Practice Committee with Nurses' Association . . .* Authorized the establishment of a Joint Practice Committee (with the nursing and medical professions) and empowered the President to name members.

*Separate Department of Mental Health . . .* Received a report of the MSNJ Special Task Force concerning a meeting with Commissioner Clifford of the Department of Institutions and Agencies which revealed that the Commissioner was neutral on the issue of a separate Department of Mental Health in New Jersey; that it was his opinion that no one had presented any evidence in support of a separate department nor shown why the purportedly inadequate mental health program in New Jersey cannot be upgraded through the Department of Institutions and Agencies; and that Governor Cahill was unalterably opposed to the creation of a separate Department of Mental Health.

*Medical-Surgical Plan—Trustee Nominees . . .* Approved the nominations of the following for the indicated terms on the Board of Trustees of MSP:

Frederick Hipp, Ph.D. (3 yrs.) NJ Education Association  
William M. Chase, M.D. (2 yrs.) Internist  
A. Guy Campo, M.D. (1 yr.) Family Physician

*Radiation Protection Fee Schedule . . .* Directed (in reply to a communication from the Essex County Medical Society recording its opposition to the Radiation Protection Fee Schedule) that the Essex County Medical Society be informed that since the schedule has been adopted and the administrative procedure act followed, there is nothing that can be done legally by the Society to affect the schedule.

## Amalgamation of Internal Medicine Organizations

Officials of the American College of Physicians (ACP) and the American Society of Internal Medicine (ASIM) have recommended to their governing bodies that the organizations be amalgamated "providing the necessary details can be worked out so that equal emphasis will be given to education in the clinical sciences and education in the science of health care delivery."

The release said: "It has now become obvious that we cannot separate educational activities from social and economic factors and that the strengths of both societies are needed if they are to become leaders and spokesmen for internal medicine."

The ACP was organized "for the purpose of considering and discussing medical and scientific topics" and "to maintain and advance the highest possible standards in medical education, medical practice, and research" while the ASIM was established "to study the scientific, economic, social, and political aspects of medicine at a national level in order to secure and maintain the best patient care and the highest standard of practice in internal medicine.

Under the proposed plans for amalgamation, a new organization would be created to be known as the American College of Physicians-American Society of Internal Medicine with membership consisting of current members of ASIM and ACP. The new organization would be the fourth largest national medical society. It will be built around state, territorial, and Canadian provincial component chapters with locally-elected representatives to a national deliberative body. This body would be responsible for electing officers and the board of directors as well as initiating, recommending, and reviewing policy established by the Board.

### Patronize Our Advertisers

The American Society of Internal Medicine, founded in 1956, now has offices in San Francisco. The American College of Physicians, established in 1915, has its headquarters in Philadelphia. The location of the new ACP-ASIM has not been determined, but "a practical consideration is the present ACP headquarters (at 4200 Pine Street, Philadelphia) which is adequate and debt-free."

The points of agreement, as drafted by the ACP-ASIM Liaison Committee, have been approved by the Board of Regents of the American College of Physicians and the Board of Trustees of the American Society of Internal Medicine. The Liaison Committee said it believes that final action on the amalgamation can be taken in April, 1973, when both organizations have annual meetings in Chicago.

## Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during July 1972:

	1972 July	1971 July
Aseptic meningitis	29	10
Primary encephalitis	0	3
Hepatitis: Total	244	405
Infectious	165	309
Serum	79	96
Malaria: Total	1	8
Military	0	6
Civilian	1	2
Meningococcal meningitis	3	4
Mumps	19	76
German measles	6	11
Measles	8	61
Salmonella	85	171
Shigella	5	25

### Optimal Age for Administering Measles Vaccine

Recent studies from around the country serve to emphasize that children receiving measles vaccine prior to one year of age may not be protected adequately. An outbreak among 57 children in Ocean County has made us aware of this problem. The outbreak was confined

to the lower age groups with 11 less than 5 years old, 35 between 5 and 9, and 11 age 10 or older. All the pre-school children with measles were unvaccinated. Among the school-age children, 56 per cent had received measles vaccine. When the immunization histories were reviewed, it was noted that nearly 75 per cent of these previously vaccinated children with clinical measles had received vaccine prior to one year of age. When vaccine efficacy was compared in the school-age children for those receiving vaccine prior to one year of age and those receiving vaccine at an age older than one year, a significant difference was observed. Vaccine efficacy for those receiving a vaccine at less than a year of age was inadequate; for those receiving the vaccine at greater than one year of age the vaccine efficacy was satisfactory.

Several different kinds of studies have pointed out the inadequacy of vaccinating children prior to one year of age. Serum surveys of children who have received vaccine at one year of age and later have indicated that 95 per cent of these will have measurable antibody titers. Only 80 to 85 per cent of children receiving vaccine at 9 or 10 months of age will have measurable antibody titers. Other measles outbreak investigations from around the country have yielded data similar to those reported here.

At present, the Public Health Service Advisory Committee on Immunization Practices recommends that measles vaccine should be given at age 12 months or later. The Committee has recommended also that children who have previously received measles vaccine at less than 11 months of age be revaccinated. The New Jersey State Health Department concurs in both of these recommendations.

### Support

**The Society for Relief  
of Widows and Orphans**

## Medical College Notes

**Stanley S. Bergen, Jr., M.D.**  
President, CMDNJ

Each year we face a growing shortage of physicians in New Jersey, despite a continuing effort on the part of our hospitals to attract and keep qualified interns and residents. This situation is further aggravated by a shortage of space in our medical schools which forces men and women to attend foreign medical schools. Many do not return to intern or practice medicine in New Jersey because deficiencies in their clinical training create difficulties in acceptance into approved internships at our hospitals.

In an attempt to assist graduates of foreign medical schools to become eligible for internship in New Jersey hospitals, the College of Medicine and Dentistry of New Jersey has instituted a special 40-week program to supplement their clinical training. Nearly 30 students have elected to participate in the program at six New Jersey hospitals during the next ten months—medicine (12 weeks), surgery (10 weeks), pediatrics, psychiatry, obstetrics and gynecology (6 weeks each). About three-quarters of the students participating in the program are from New Jersey.

When the project was announced in April of this year, it was pointed out that the program should aid our hospitals to provide better health care to New Jerseyans by facilitating the entry of fully qualified, foreign-educated medical students into the mainstream of American medicine. Physicians and hospital administrators are well aware of the fact that nearly one-third of our internship vacancies went unfilled last year.

While the program is meant to assist men and women who have been forced to go abroad for medical education, it does not mean a lowering of the standards of excellence in medical education. Requirements for admission assure careful screening: (1) completion of undergraduate premedical work acceptable for entry into an accredited American medical school; (2) attendance at a medical school

outside the United States, Puerto Rico, or Canada, recognized by the World Health Organization; (3) completion of formal requirements of the foreign school, except foreign internship and/or "social service"; (4) academic records acceptable to the College; (5) successful completion of a special admission examination. There will be continuing review of each student's progress.

Qualified students may apply directly to the participating hospitals: Jersey City Medical Center, Jersey City; Morristown Memorial Hospital, Morristown; Muhlenberg Hospital, Plainfield; Raritan Valley Hospital, Green Brook; Overlook Hospital, Summit; and St. Joseph's Hospital, Paterson. Most of these units are current affiliates of one of the medical schools or have indicated their interest in future affiliation.

The program has been approved by the Council on Medical Education of the American Medical Association. It will be conducted under supervision of physicians holding faculty appointments in one of the medical schools of the College of Medicine and Dentistry of New Jersey. These faculty members will be complemented by practicing physicians on the staffs of participating hospitals. We believe that joint faculty and voluntary staff efforts will provide the optimum educational environment for students who are seeking the exposure necessary to sharpen their clinical skills. A representative committee of faculty members and hospital medical educators is guiding program development and curriculum structure.

Acceptance of the program by foreign medical students has been favorable. Some have said it is an essential element in the completion of their medical education. Although the College is reportedly one of fourteen medical schools in the United States participating in this type of program, ours apparently is the largest in existence. This is an initial effort. Its success will help to determine both future curricula and size of the problem. Hopefully, the growth of the College will mean that fewer students will be compelled to go abroad to train for careers in medicine.






0.5 Gm tablets  
**ORINASE<sup>®</sup>**  
tolbutamide, Upjohn

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001  
JA72-2407-6  
© 1972 The Upjohn Company

# May 1957

The age of semi-synthetic penicillins  
begins at Beecham Research Laboratories.



The crucial experiment: conversion of 6-aminopenicillanic acid (6-APA) into benzylpenicillin by treatment with phenylacetyl chloride. We've come a long way since 1957. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today.

Need we say more?

Prescribe the discoverer's brands:

**Totacillin<sup>®</sup>** ampicillin trihydrate  
**Pyopen<sup>®</sup>** disodium carbenicillin  
**Bactocill<sup>®</sup>** sodium oxacillin  
and more to come

**Beecham-Massengill  
Pharmaceuticals **BMP****

Div. of Beecham Inc., Bristol, Tennessee 37620

☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin. ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin. ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

# 1972-1973

## Committees and Councils

### STANDING COMMITTEES

#### Annual Meeting

Arthur Bernstein, M.D., *Chairman* (1975) Maplewood  
 John J. Thompson, M.D., *Vice-Chairman*  
 (1974) Caldwell  
 Nicholas A. Bertha, M.D. (1973) Wharton  
 Donald C. Davidson, M.D. (1973) Atlantic City  
 James A. Rogers, M.D. (1974) Paterson  
 Robert E. Verdon, M.D. (1975) Cliffside Park  
 Louis F. Albright, M.D., *Secretary*  
 Ex-officio Spring Lake

#### Scientific Exhibits

John J. Thompson, M.D., *Chairman* Caldwell  
 H. Irving Dunn, M.D. Bay Head  
 George L. Erdman, M.D. Summit  
 Arthur Krosnick, M.D. Trenton  
 Martin Rush, M.D. Red Bank

#### Scientific Program (Sections)

##### Allergy

Arthur Fost, M.D., *Chairman* North Caldwell  
 Frederic A. Schulauer, M.D., *Secretary* Westfield

##### Anesthesiology

H. A. Ferrari, M.D., *Chairman* Summit  
 Joseph A. Cox, M.D., *Secretary* Short Hills

##### Cardiovascular Diseases

Harry A. Roselle, M.D., *Chairman* Englewood  
 Lawrence A. Lubow, M.D., *Secretary* Morristown

##### Chest Diseases

Albert Mintzer, M.D., *Chairman* Elizabeth  
 John J. Tambascia, M.D., *Secretary* Kendall Park

##### Clinical Pathology

Martin J. Salwen, M.D., *Chairman* Long Branch  
 Paul T. Wertlake, M.D., *Secretary* Short Hills

##### Dermatology

James T. Vail, Jr., M.D., *Chairman* Summit  
 Alfred J. Shapiro, M.D., *Secretary* Long Branch

##### Gastroenterology and Proctology

Dave B. Swerdlow, M.D., *Chairman* Montclair  
 David Kaufman, M.D., *Secretary* Elizabeth

##### General Practice

Edward H. Weiser, M.D., *Chairman* Sussex  
 Frank C. Snope, M.D., *Secretary* Flemington

##### Medicine

James G. Kehler, Jr., M.D., *Chairman* Woodbury  
 Paul K. Bornstein, M.D., *Secretary* Asbury Park

##### Neurosurgery and Neurology

George L. Becker, Jr., M.D., *Chairman* Paterson  
 Henry R. Liss, M.D., *Secretary* Chatham

##### Obstetrics and Gynecology

Ralph H. Van Meter, M.D., *Chairman* Moorestown  
 William H. Ainslie, M.D., *Secretary* Metuchen

#### Ophthalmology

Donald A. Fonda, M.D., *Chairman* Ridgewood  
 Vincent B. Pica, M.D., *Secretary* Trenton

#### Orthopedic Surgery

Merle H. Katzman, M.D., *Chairman* Tenafly  
 Martin L. Sorger, M.D., *Secretary* Montclair

#### Otolaryngology

Howard E. Hock, M.D., *Chairman* Glen Ridge  
 Joseph M. Lenczyk, M.D., *Secretary* Shrewsbury

#### Pediatrics

Glenn P. Lambert, M.D., *Chairman* Flemington  
 Anthony P. DeSpirito, M.D., *Secretary* Asbury Park

#### Plastic and Reconstructive Surgery

Ursula W. Steinberg, M.D., *Chairman* Plainfield  
 Morton H. Goldstein, M.D., *Secretary* New Brunswick

#### Psychiatry

Chester L. Trent, M.D., *Chairman* Asbury Park  
 Alvin Friedland, M.D., *Secretary* East Orange

#### Radiology

Allan J. Scher, M.D., *Chairman* Morristown  
 David N. Bramwit, M.D., *Secretary* Hackensack

#### Rheumatism

Leroy H. Hunninghake, M.D., *Chairman* Princeton  
 Sheldon Solomon, M.D., *Secretary* Marlton

#### Surgery

Joseph Alpert, M.D., *Chairman* Millburn  
 John J. White, M.D., *Secretary* Princeton

#### Urology

Richard Fadil, M.D., *Chairman* Passaic  
 Anthony Del Gaizo, M.D., *Secretary* Paterson

#### Credentials

Louis F. Albright, M.D., *Chairman*  
 (Secretary) Spring Lake  
 Elbert H. Pogue, M.D., *Vice-Chairman*  
 (1974) Elizabeth  
 Frank J. T. Aitken, M.D. (1975) Bridgeton  
 Thaddeus Balinski, M.D. (1973) Perth Amboy  
 Charles E. Gilpatrick, M.D. (1975) Carney's Point  
 John W. Nicholson, III, M.D. (1973) Moorestown  
 Howard J. Rosenbauer, M.D. (1974) Hackensack

#### Finance and Budget

Nicholas E. Marchione, M.D., *Chairman*  
 (1974) Vineland  
 David Eckstein, M.D., *Vice-Chairman*  
 (1975) Trenton  
 G. Thomas DeFusco, M.D. (1974) Deal  
 Louis G. McAfoos, Jr., M.D. (1975) Cherry Hill  
 I. Edward Ornaf, M.D. (1973) Cherry Hill  
 John S. Van Mater, M.D. (1973) New Brunswick  
 Samuel J. Lloyd, M.D., *Treasurer*  
 Ex-Officio Trenton

#### Honorary Membership

Ralph M. L. Buchanan, M.D., *Chairman*  
 (1973) Phillipsburg  
 Charles H. Calvin, M.D., *Vice-Chairman*  
 (1975) Edison  
 Elton W. Lance, M.D. (1974) Rahway



# **Medical Defense and Insurance**

Paul J. Kreutz, M.D., *Chairman*  
(1975) ..... Elizabeth  
Jesse Schulman, M.D., *Vice-Chairman*  
(1974) ..... Lakewood  
Alfred A. Alessi, M.D. (1975) ..... Oradell  
Irving P. Borsher, M.D. (1974) ..... Newark  
Anthony P. DeSpirito, M.D. (1973) ..... Asbury Park  
William G. Kuhn, Jr., M.D. (1973) ..... New Brunswick  
Louis F. Albright, M.D. *Secretary*,  
Ex-Officio ..... Spring Lake  
Ernest C. Hillman, Jr., M.D., *Consultant* ..... Glen Ridge  
Benjamin F. Slobodien, M.D.,  
*Consultant* ..... Perth Amboy

# **Medical Education**

James A. Rogers, M.D., *Chairman* (1973) ..... Paterson  
William T. Snagg, M.D., *Vice-Chairman*  
(1975) ..... Camden  
Arthur Bernstein, M.D. (1974) ..... Maplewood  
John A. Kinzel, M.D. (1974) ..... Trenton  
Frank C. Snope, M.D. (1973) ..... Flemington  
Edward H. Weiser, M.D. (1975) ..... Sussex  
William F. Minogue, M.D., *Consultant* ..... Mountainside  
William S. Vaun, M.D., *Consultant* ..... Long Branch  
Edward A. Wolfson, M.D. *Consultant* ..... Glen Rock

# **Medical Student Loan Fund**

William Greifinger, M.D. *Chairman*  
(1975) ..... Belleville  
Charles H. Calvin, M.D., *Vice-Chairman*  
(1973) ..... Edison  
Charles Cunningham, M.D. (1973) ..... Vineland  
Joseph R. Jehl, M.D. (1974) ..... Clifton  
William R. Muir, M.D. (1974) ..... Mount Holly

# **Physicians' Relief Fund**

Joseph J. Kline, M.D., *Chairman*  
(1974) ..... Trenton  
Frederick W. Durham, M.D., *Vice-Chairman*  
(1973) ..... Haddonfield  
John J. Bedrick, M.D. (1974) ..... Bayonne  
A. Guy Campo, M.D. (1973) ..... Westville  
Frank Y. Watson, M.D. (1975) ..... Montclair

# **Publication**

Daniel B. Roth, M.D., *Chairman*  
(1973) ..... Teaneck  
Arthur Krosnick, M.D. (1974) ..... Trenton  
John F. Marshall, M.D. (1975) ..... Trenton  
Matthew E. Boylan, M.D. *President-Elect*,  
Ex-Officio ..... Jersey City  
Louis F. Albright, M.D., *Secretary*,  
Ex-Officio ..... Spring Lake  
Henry A. Davidson, M.D., *Editor*,  
Ex-Officio ..... East Orange

# **Revision of Constitution and Bylaws**

Hillel M. Ben-Asher, M.D., *Chairman*  
(1975) ..... Morristown  
Meyer L. Abrams, M.D., *Vice-Chairman*  
(1974) ..... Willingboro  
Emanuel Abraham, M.D. (1975) ..... Asbury Park  
Richard Berlin, M.D. (1973) ..... Englewood  
Jesse W. Carll, M.D. (1973) ..... Bridgeton  
William R. Muir, M.D. (1974) ..... Mount Holly  
Louis F. Albright, M.D., *Secretary*,  
Ex-Officio ..... Spring Lake  
Joseph M. Gannon, M.D., *Consultant* ..... Plainfield

# **Woman's Auxiliary**

William J. Roe, M.D., *Chairman* (1975) ..... Englewood  
Charles Gandek, M.D., *Vice-Chairman*  
(1975) ..... Edison

Edward M. Coe, M.D. (1973) ..... Cranford  
Frederick W. Durham, M.D. (1974) ..... Haddonfield  
Jesse T. Glazier, M.D. (1973) ..... Newark  
Paul Harrison, M.D. (1974) ..... Mount Holly

# **ADMINISTRATIVE COUNCILS**

## **Legislation**

Henry J. Mineur, M.D., *Chairman*  
(1975) ..... Cranford  
Meyer L. Abrams, M.D., *Vice-Chairman*  
(1974) ..... Willingboro  
Donald P. Burt, M.D. (1975) ..... Morristown  
A. Guy Campo, M.D. (1973) ..... Westville  
John J. Crosby, Jr., M.D. (1973) ..... Jersey City  
John D. Franzoni, M.D. (1973) ..... Trenton  
Leon A. Fraser, M.D. (1973) ..... Trenton  
Winton H. Johnson, M.D. (1975) ..... Hackensack  
John S. Madara, M.D. (1975) ..... Salem  
Daniel J. O'Regan, M.D. (1974) ..... Jersey City  
Francis A. Pflum, M.D. (1974) ..... Asbury Park  
John R. Tobey, M.D. (1974) ..... Newark  
A. Guy Campo, M.D., *Chairman, Board of Trustees*,  
Ex-Officio ..... Westville  
E. Powers Mincher, *Legislative Analyst* ..... Pennington

## **Medical Services**

Louis K. Collins, M.D. *Chairman* (1974) ..... Glassboro  
Karl T. Franzoni, M.D., *Vice-Chairman*  
(1973) ..... Trenton  
Donald T. Akey, M.D. (1974) ..... Metuchen  
Robert H. Areson, M.D. (1975) ..... Montclair  
David R. Brewer, Jr., M.D. (1975) ..... Woodbury  
Arthur C. Dietrick, M.D. (1975) ..... Mount Holly  
William A. Dwyer, Jr., M.D. (1973) ..... Paterson  
David Flinker, M.D. (1975) ..... Moorestown  
Robert E. Fullilove, Jr., M.D. (1973) ..... Newark  
Robert S. Gamon Jr., M.D. (1974) ..... Cherry Hill  
Joseph A. Lepree, M.D. (1974) ..... Elizabeth  
James S. Todd, M.D. (1973) ..... Ridgewood  
Matthew E. Boylan, M.D., *President-Elect*  
Ex-Officio ..... Jersey City  
Frank M. Galio, M.D., *Consultant* ..... Bloomfield  
Nicholas E. Marchione, M.D. *Consultant* ..... Vineland

## **Mental Health**

Robert S. Garber, M.D., *Chairman*  
(1975) ..... Belle Mead  
Edward A. Schauer, M.D., *Vice-Chairman*  
(1973) ..... Farmingdale  
Miles E. Drake, M.D. (1973) ..... Vineland  
Sidney M. Hodas, M.D. (1974) ..... Red Bank  
Evelyn P. Ivey, M.D. (1975) ..... Farmingdale  
Clarence W. Jaggard, M.D. (1975) ..... Woodbury  
Arnold Kallen, M.D. (1974) ..... Millburn  
Seymour F. Kuvin, M.D. (1973) ..... Livingston  
J. Lloyd Morrow, M.D. (1974) ..... Passaic  
Eugene V. Resnick, M.D. (1974) ..... Paramus  
John R. Rushton, III, M.D. (1973) ..... Camden  
Martin H. Weinberg, M.D. (1975) ..... Trenton  
E. Vernon Davis, M.D., *Immediate*  
*Past-President, Ex-Officio* ..... Mount Holly

## **Public Health**

Robert G. Salasin, M.D., *Chairman*  
(1975) ..... North Wildwood  
Kendrick P. Lance, M.D., *Vice-Chairman*  
(1973) ..... Paterson  
Roslyn Barbash, M.D. (1973) ..... Teaneck  
William M. Chase, M.D. (1973) ..... East Orange  
Anthony P. DeSpirito, M.D. (1975) ..... Asbury Park  
Henry L. Drezner, M.D. (1974) ..... Trenton

George I. Erdman, M.D. (1974) ..... Summit  
 Rudolph G. Matflerd, M.D. (1974) ..... New Brunswick  
 Thomas F. McLaughlin, M.D. (1973) ..... Metuchen  
 John J. A. Pastore, M.D. (1975) ..... Vineland  
 Francis E. Rieman, M.D. (1975) ..... North Bergen  
 Frederick C. Steller, M.D. (1974) ..... Spring Lake  
 James A. Rogers, M.D., *First Vice-President*  
     Ex-Officio ..... Paterson  
 James R. Cowan, Sr., M.D. *Consultant* ..... Trenton  
 Martin Goldfield, M.D., *Consultant* ..... Trenton

#### Public Relations

Howard D. Slobodien, M.D., *Chairman*  
     (1973) ..... Perth Amboy  
 John P. Kengeter, M.D., *Vice-Chairman*  
     (1974) ..... Toms River  
 Frank R. Begen, M.D. (1975) ..... Teaneck  
 John J. Crosby, Jr., M.D. (1975) ..... Jersey City  
 William N. Evans, M.D. (1973) ..... Mount Holly  
 Robert Holman, M.D. (1975) ..... Pompton Plains  
 John J. McGuire, M.D. (1973) ..... Newark  
 Gastone A. Milano, M.D. (1975) ..... Atlantic City  
 John A. Sakson, M.D. (1974) ..... Yardley, Pa.  
 Irwin Smith, M.D. (1974) ..... Willingboro  
 Ford C. Spangler, M.D. (1973) ..... Salem  
 Frank Y. Watson, M.D. (1974) ..... Montclair  
 John J. McGuire, M.D., *2nd Vice-President*  
     Ex-Officio ..... Newark

## SPECIAL COMMITTEE TO THE COUNCIL ON MEDICAL SERVICES

#### Occupational Health, Workmen's Compensation, and Rehabilitation

Delma W. Caldwell, M.D., *Chairman* ..... Westfield  
 Joshua N. Zimskind, M.D., *Vice-Chairman* .. Trenton  
 James F. Collier, M.D. .... Haddonfield  
 Elmer J. Elias, M.D. .... Trenton  
 John W. Holdcraft, M.D. .... Woodbury  
 Michael N. Jennings, M.D. .... Matawan  
 Carl A. Maxwell, M.D. .... Phillipsburg  
 William D. Van Riper, M.D. .... Green Pond  
 Mathilda R. Vaschak, M.D. .... New Brunswick  
 Nelson C. Walker, M.D. .... Hackensack  
 Ralph A. Young, M.D. .... Maplewood  
 Jarvis Smith, M.D., *Consultant* ..... Trenton

## SPECIAL COMMITTEES TO THE COUNCIL ON MENTAL HEALTH

#### Alcoholism

Robert S. Albahary, M.D., *Chairman* .. New Brunswick  
 Robert E. Adams, M.D. .... Morrisville, Pa.  
 Joseph P. Greeley, M.D. .... Westfield  
 Edwin D. Rogers, M.D. .... Princeton  
 George Rogers, M.D. .... Camden  
 Robert E. Verdon, M.D. .... Cliffside Park

#### Drug Abuse

Hans W. Freymuth, M.D., *Chairman* ..... Trenton  
 Mary Ann Bartusis, M.D. .... Trenton  
 Granville L. Jones, M.D. .... Summit  
 Harry E. LeFever, M.D. .... Cherry Hill  
 Edward A. Wolfson, M.D. .... Glen Rock

#### Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., *Chairman* ..... Paramus  
 Joseph C. Bogdan, M.D. .... Neptune City

Jay W. Fidler, M.D. .... Plainfield  
 Bradford Judd, M.D. .... Shrewsbury  
 Joseph J. Kline, M.D. .... Trenton  
 Alan H. Kulick, M.D. .... Vineland

#### Mental Retardation

Miles E. Drake, M.D., *Chairman* ..... Vineland  
 Eugene Revitch, M.D. .... Plainfield  
 Catherine E. Spears, M.D. .... Chatham  
 Robert A. Weinstein, M.D. .... Newton  
 Harry Volken, M.D. .... Paterson

#### Neurological and Related Disorders

J. Lloyd Morrow, M.D., *Chairman* ..... Passaic  
 Michael Canelis, M.D. .... Morristown  
 Josiah J. Pegues, M.D. .... Mount Holly  
 Ira S. Ross, M.D. .... South Orange  
 Walter Scheuerman, M.D. .... Trenton

## SPECIAL COMMITTEES TO THE COUNCIL ON PUBLIC HEALTH

#### Cancer Control

Roy T. Forsberg, M.D., *Chairman* ..... Westfield  
 Sherman Garrison, M.D. .... Bridgeton  
 John A. Ianacone, M.D. .... Paterson  
 Warren H. Knauer, M.D. .... Hillside  
 Bernard J. Koven, M.D. .... Englewood  
 Charles S. Krueger, M.D. .... Mount Holly

#### Child Health

William J. Fatley, M.D., *Chairman* ..... Brielle  
 Herbert L. Cole, M.D. .... Wayne  
 Robert E. Jennings, M.D. .... South Orange  
 Glenn P. Lambert, M.D. .... Flemington  
 Bernard N. Millner, M.D. .... Trenton  
 Milton Prystowsky, M.D. .... Nutley  
 William L. Rumsey, Jr., M.D. .... Elizabeth  
 Sidney Tucker, M.D. .... Perth Amboy

#### Conservation of Vision, Hearing, and Speech

Alfonse A. Cinotti, M.D., *Chairman* ..... Jersey City  
 Bernard A. Balsis, M.D. .... Trenton  
 Ralph L. Dicker, M.D. .... Dover  
 Samuel Diskan, M.D. .... Atlantic City  
 Joseph H. Kler, M.D. .... New Brunswick  
 Oram R. Kline, Jr., M.D. .... Camden  
 Rowan C. Pearce, Jr., M.D. .... Haddonfield  
 Isadore M. Schnee, M.D. .... Paterson  
 Ralph E. Siegel, M.D. .... Perth Amboy  
 Ralph A. Skowron, M.D. .... Cherry Hill  
 Aris M. Sophocles, M.D. .... Trenton  
 Robert Stern, M.D. .... Mount Holly  
 D. Blair Sulouff, M.D. .... Morristown  
 Anthony M. Sellitto, M.D., *Consultant* .. South Orange

#### Environmental Health

Roslyn Barbash, M.D., *Chairman* ..... Teaneck  
 Mary B. Hall, M.D. .... Trenton  
 Richard M. Musgnug, M.D. .... Medford Lakes  
 E. Spencer Paisley, M.D. .... Haddon Heights  
 Frank L. Rosen, M.D. .... Maplewood  
 William I. Weiss, M.D. .... Livingston  
 Meyer T. Weissman, M.D. .... Elizabeth

#### Maternal and Infant Welfare

Leopold E. Thron, M.D., *Chairman* ..... Paterson  
 Edward N. Conando, M.D. .... Millburn  
 Robert A. Cosgrove, M.D. .... Jersey City  
 Edward Foord, M.D. .... Burlington  
 Charles D. Foster, III, M.D. .... Pitman

John D. Franzoni, M.D. . . . . Trenton  
 Calvin Hahn, M.D. . . . . Vineland  
 Herbert F. Johnson, M.D. . . . . Camden  
 John D. Preece, M.D. . . . . Trenton  
 Daniel B. Roth, M.D. . . . . Teaneck  
 Harold Schwartz, M.D. . . . . Millburn  
 Jack E. Shangold, M.D. . . . . Perth Amboy  
 Bernard N. Millner, M.D., *Consultant* . . . . Trenton

Spencer T. Snedecor, M.D. . . . . Hackensack  
 Marie A. Sena, M.D., *Consultant* . . . . Toms River

#### Medicine and Religion

Watson E. Neiman, M.D., *Chairman* . . . Cinnaminson  
 John J. Bedrick, M.D. . . . . Bayonne  
 Charles H. Calvin, M.D. . . . . Edison  
 John S. Madara, M.D. . . . . Salem  
 Thomas H. McGlade, M.D. . . . . Camden  
 Luke A. Mulligan, M.D. . . . . Leonia

## SPECIAL COMMITTEES

#### Emergency Medical Care

Jack R. Karel, M.D., *Chairman* . . . . Hillside  
 R. Winfield Betts, M.D., *Vice-Chairman* . . . . Medford  
 Clifford B. Blasi, M.D. . . . . Jersey City  
 Charles P. Campbell, M.D. . . . . Hackensack  
 John A. Flood, Jr., M.D. . . . . Trenton  
 Dorson S. Mills, M.D. . . . . Elmer  
 Frank R. Schell, M.D. . . . . Wayne

#### Project Hope and Vietnam

Thomas C. DeCecio, M.D., *Chairman* . . . Cliffside Park  
 Harold L. Colburn, Jr., M.D. . . . . Moorestown  
 J. Leonard Grief, M.D. . . . . Dover

#### Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* . . . Vineland  
 Albert F. Moriconi, M.D. . . . . Trenton  
 Emanuel M. Satulsky, M.D. . . . . Elizabeth

## 1972-1973 SPECIAL COMMITTEES SPECIAL LIAISON REPRESENTATIVES

#### Academy of Medicine of New Jersey

- (1) Board of Trustees/Liaison Committee  
 (Liaison requested by Academy—6/19/66)  
 A. Guy Campo, M.D. . . . . Westville  
 James A. Rogers, M.D. . . . . Paterson  
 Emanuel M. Satulsky, M.D. . . . . Elizabeth
- (2) Post-Graduate Medical Education Study Committee  
 (Representative requested by Academy—11/15/64)  
 James A. Rogers, M.D., *Chairman*,  
*Committee on Medical Education* . . . Paterson  
 William T. Snagg, M.D., *Vice-Chairman*,  
*Committee on Medical Education* . . . Camden

#### American Medical Association-Education Research Foundation

(Liaison requested by AMA—10/7/51)  
 William Greifinger, M.D., *Chairman, Committee on  
 Medical Student Loan Fund* . . . . Belleville

#### Audit Review Committee (1971-72 Audit)

(Appointed annually by Board to review previous  
 year's audit)  
 Louis F. Albright, M.D., *Chairman* . . . Spring Lake  
 Edward G. Bourns, M.D. . . . . Westfield  
 Matthew E. Boylan, M.D. . . . . Jersey City  
 William J. D'Elia, M.D. . . . . Neptune City  
 I. Edward Orna, M.D. . . . . Camden  
 Consultants:  
 Samuel J. Lloyd, M.D., *Treasurer* . . . Trenton  
 Nicholas E. Marchione, M.D., *Chairman, Com-  
 mittee on Finance and Budget* . . . Vineland

#### Bicentennial Celebration, Committee on National

(Established by Board of Trustees 7/19/70 to in-  
 vestigate the possibility of MSNJ's participation in the  
 National Bicentennial Celebration in 1976)  
 Morris H. Saffron, M.D., *Chairman* . . . Passaic  
 David R. Brewer, Jr., M.D. . . . . Woodbury  
 Peter J. Guthorn, M.D. . . . . Neptune City  
 Fred B. Rogers, M.D. . . . . Trenton

#### Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank  
 Association—4/25/69)  
 Harry B. Lockhead, M.D. . . . . Woodbury

#### Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP  
 —4/16/60)  
 A. Guy Campo, M.D., *Chairman*,  
*Board of Trustees* . . . . Westville  
 William J. D'Elia, M.D., *President* . . . Neptune City  
 Mr. Richard I. Nevin, *Executive Director* . . . Trenton  
 Equal representation from:  
 Medical-Surgical Plan of New Jersey  
 Hospital Service Plan of New Jersey  
 New Jersey Hospital Association

#### Board of Institutional Trustees, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)  
 Frank J. Hughes, M.D. (1979) . . . . Gloucester

#### Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing—11/21/65)  
 Henry J. Mineur, M.D. . . . . Cranford

#### Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of  
 Law and Public Safety—9/61)  
 Board of Trustees (Reaffirmed by Board of Trustees  
 5/9/72)

#### Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic  
 Safety—9/17/61—appointed by Director of Motor  
 Vehicles)  
 Harry A. Kaplan, M.D. . . . . Trenton  
 James G. Kehler, M.D. . . . . Woodbury  
 John C. Wood, M.D. . . . . Trenton



#### Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross,  
M.D., CMDNJ at Rutgers—12/20/70)  
Arthur Bernstein, M.D. .... Maplewood  
Harold L. Colburn, Jr., M.D. .... Moorestown

#### Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health  
Planning Agency 12/16/69)  
Nicholas E. Marchione, M.D., *State Health  
Planning Council* .... Vineland  
Irving P. Borsher, M.D., *Health Care  
Costs Committee* .... Newark  
Arthur Bernstein, M.D., *Medicaid  
Committee* .... Maplewood  
James A. Rogers, M.D., *Medical Education  
Facilities Committee* .... Paterson

#### Crippled Children Commission, State

(Appointed by Governor for 5-year term)  
Frederick G. Dilger, M.D. .... Hackensack

#### Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP—8/21/60—Quorum:  
4 members)  
1st District—  
Ralph M. L. Buchanan, M.D.,  
*Chairman* .... Phillipsburg  
Robert F. Zimmerman, M.D. .... Morristown  
2nd District—  
John J. Bedrick, M.D. .... Bayonne  
Robert A. Cosgrove, M.D. .... Jersey City  
3rd District—  
John S. VanMater, M.D. .... New Brunswick  
John A. Kinzel, M.D. .... Trenton  
4th District—  
John C. Clark, M.D. .... Asbury Park  
Robert S. Gamon, Jr., M.D. .... Cherry Hill  
5th District—  
A. Guy Campo, M.D. .... Westville  
Nicholas E. Marchione, M.D. .... Vineland

#### Education, State Department of

(Liaison requested by the Assistant Commissioner of  
Education—9/21/58)  
William J. Farley, M.D., *Chairman, Special  
Committee on Child Health* .... Brielle

#### Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by Department of Education—  
10/28/68)  
William J. Farley, M.D. .... Brielle

#### Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles  
—7/29/66)  
J. Berkeley Gordon, M.D. .... Rumson

#### Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 (b))  
William J. D'Elia, M.D., *President  
(Chairman)* .... Neptune City  
Matthew E. Boylan, M.D.,  
*President-Elect* .... Jersey City  
James A. Rogers, M.D.,  
*First Vice-President* .... Paterson  
John J. McGuire, M.D.,  
*Second Vice-President* .... Newark  
A. Guy Campo, *Chairman of the  
Board of Trustees* .... Westville

#### Health Careers Service, New Jersey

(Physician representation established by Board of  
Trustees 7/20/69)  
Karl T. Franzoni, M.D. .... Trenton

#### Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers  
Service—7/19/64)  
Presidents of Component Societies

#### Health Insurance Conference

(Committee established at request of Health Insurance  
Council—3/24/57)  
Louis F. Albright, M.D., *Secretary  
(Chairman)* .... Spring Lake  
William J. D'Elia, M.D., *President* .... Neptune City  
Matthew E. Boylan, M.D.,  
*President-Elect* .... Jersey City  
James A. Rogers, M.D., *First  
Vice-President* .... Paterson  
John J. McGuire, M.D., *Second  
Vice-President* .... Newark  
Mr. Richard I. Nevin, *Executive Director* .... Trenton  
Charles L. Cumliff, M.D. .... Jersey City

#### Heart Disease, Cancer, and Stroke

University City Science Center, Philadelphia  
(Established at invitation of University City Science  
Center—12/63)  
Louis K. Collins, M.D. .... Glassboro

#### Historian-Archivist

(Created at the suggestion of the Executive Director—  
1/13/57)  
Morris H. Saffron, M.D. (Appointed 5/67) .. Passaic

#### Hospital Association, New Jersey

(Invitation extended to Executive Director to serve  
on the Board of Trustees—12/17/67)  
Mr. Richard I. Nevin, *Executive Director* .... Trenton

#### Hospital Advisory Council, State Department of Institutions and Agencies

(Appointed by the Board of Institutional Trustees  
for a 4-year term)  
Luke A. Mulligan, M.D. (December 1972) .. Leonia

#### House Maintenance, Staff Policies, and Personnel Relations

(Special Committee created by Board of Trustees—  
9/21/58)  
William J. D'Elia, M.D., *President  
(Chairman)* .... Neptune City  
Matthew E. Boylan, M.D.,  
*President-Elect* .... Jersey City  
Louis F. Albright, M.D., *Secretary* .... Spring Lake  
Samuel J. Lloyd, M.D., *Treasurer* .... Trenton  
A. Guy Campo, M.D., *Chairman,  
Board of Trustees* .... Westville  
Nicholas E. Marchione, M.D., *Chairman of  
the Committee on Finance and Budget* .... Vineland  
Mr. Richard I. Nevin, *Executive Director* .... Trenton

#### HRET (Hospital Research and Educational Trust of New Jersey), Advisory Council to

(MSNJ representative requested by HRET. Appoint-  
ment made by President 2/13/71. Council will  
assist HRET in processing data previously handled  
by State Health Facilities Planning Council.)  
Mr. Vincent A. Maressa, *Assistant Executive Director*  
..... Trenton

#### Industrial Safety Board, New Jersey

(Appointed by the Governor—8/71)

Delma W. Caldwell, M.D. .... Linden

#### Intra-Hospital Infection, Joint Committee on

(Established at request of Commissioner of Health  
—4/8/62)

Edwin H. Albano, M.D., *Chairman* .... East Orange

Lawrence Gilbert, M.D. .... Irvington

Thomas K. Rathmell, M.D. .... Trenton

Eugene H. Kain, M.D. .... Pennsauken

Equal representation from:

State Department of Health

New Jersey Hospital Association

New Jersey State Nurses' Association

#### JEMPAC, Conference Committee with

(Established at request of JEMPAC—6/25/67)

Henry J. Mineur, M.D., *Chairman*,  
*Council on Legislation* .... Cranford

Louis K. Collins, M.D., *Chairman*,  
*Council on Medical Services* .... Glassboro

John J. McGuire, M.D., *Second*

*Vice-President* .... Newark

#### Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court—11/17/63)

A. Guy Campo, M.D. .... Westville

Paul J. Kreutz, M.D. .... Elizabeth

Samuel J. Lloyd, M.D. .... Trenton

John S. Madara, M.D. .... Salem

Nicholas E. Marchione, M.D. .... Vineland

John J. McGuire, M.D. .... Newark

Emanuel M. Satulsky, M.D. .... Elizabeth

James S. Todd, M.D. .... Ridgewood

William J. D'Elia, M.D., *President*,  
*Ex-officio* .... Neptune City

Mr. Richard I. Nevin, *Executive Director* .... Trenton

Mr. Vincent A. Maressa, *Assistant Executive Director*

.... Trenton

Mr. E. Powers Mincher, *Legal Counsel* .... Pennington

Equal representation from:

Supreme Court Committee on Relations with the  
Medical Profession

#### Legislation

##### (1) Federal Keymen

(Mechanism established by MSNJ—4/4/54—to  
serve as official intermediaries between MSNJ and  
the Federal legislators)

15 Congressional District Keymen

1 Senatorial Keyman

##### (2) State Keymen

(Mechanism established by MSNJ—7/13/52)

Keymen in 15 Legislative Districts/21 Compo-  
nent Societies

#### Medicaid, Negotiating Committee For

(Established by Board of Trustees to work with the  
State Medicaid Commission—12/22/68)

William J. D'Elia, M.D., *President* .... Neptune City

Matthew E. Boylan, M.D., *President*-  
*Elect* .... Jersey City

Louis K. Collins, M.D., *Chairman*,

*Council on Medical Services* .... Glassboro

#### Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the re-  
quest of the Department of Institutions and Agencies.  
The function of the Committee will be to act upon  
inquiries and/or complaints originating either with  
the administrators of the Medicaid Program or with  
physicians serving under the program.)

#### 1st District—

Nicholas A. Bertha, M.D. .... Wharton

#### 2nd District—

Ambrose P. Boyle, Jr., M.D. .... Fort Lee

#### 3rd District—

David Eckstein, M.D. .... Trenton

#### 4th District—

Emanuel Abraham, M.D. .... Asbury Park

#### 5th District—

David R. Brewer, Jr., M.D. .... Woodbury

#### Medicaid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by  
Department of Institutions and Agencies—6/12/69)

Donald P. Burt, M.D. .... Morristown

Arthur C. Dietrick, M.D. .... Mount Holly

John D. Franzoni, M.D. .... Trenton

Leo J. Kelly, Jr., M.D. .... South Orange

#### Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commis-  
sion—Board action 4/20/69)

A. Guy Campo, M.D. .... Westville

Anthony P. DeSpirito, M.D. .... Asbury Park

#### Medical Assistants, (State of New Jersey) American Association of

(Liaison established by MSNJ—9/15/63)

Robert C. Anderson, M.D. .... Newark

#### Medical Education of New Jersey, Office of Continuing

(Liaison requested by College of Medicine and  
Dentistry of New Jersey—4/20/72)

John F. Kustrup, M.D. .... Trenton

Arthur Bernstein, M.D. (alternate) .... Maplewood

#### Medical-Hospital-Nursing Conference (Tri-Partite)

Liaison established by MSNJ—1/13/57)

William J. D'Elia, *President* .... Neptune City

Matthew E. Boylan, M.D., *President*-  
*Elect* .... Jersey City

E. Vernon Davis, M.D. *Immediate*

*Past-President* .... Mount Holly

Mr. Richard I. Nevin, *Executive Director* .... Trenton

Equal representation from:

New Jersey Hospital Association

New Jersey State Nurses' Association

#### Medical Liaison Committees

(High-level conference groups for discussion and  
consideration of items of mutual interest)

William J. D'Elia, M.D., *President* .... Neptune City

Matthew E. Boylan, M.D., *President*-  
*Elect* .... Jersey City

E. Vernon Davis, M.D., *Immediate*

*Past-President* .... Mount Holly

Mr. Richard I. Nevin, *Executive Director* .... Trenton

(Where number of representatives from other organi-  
zation is larger than number of MSNJ representatives,  
the latter will be increased from the Presidential  
Officers to equal the former.)

##### (1) Medical-Dental

(Liaison requested by the Dental Society—6/10/51)

##### (2) Medical-Hospital

(Liaison established by MSNJ—10/25/53)

##### (3) Medical-Legal

(Liaison established by MSNJ—10/25/53)

##### (4) Medical-Nursing

(Liaison established by MSNJ—4/4/54)

##### (5) Medical-Osteopathic

(Liaison requested by Osteopathic Association—  
9/17/61)

##### (6) Medical-Pharmaceutical

(Liaison established by MSNJ—7/26/53)



**Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish a**

(Established by Board — 5/17/67 — Appointments by President)

Louis K. Collins, M.D., *Chairman* ..... Glassboro  
A. Guy Campo, M. D. .... Westville  
Sherman Garrison, M.D. .... Bridgeton  
Frank J. Hughes, M.D. .... Gloucester  
John F. Kustrup, M.D. .... Trenton  
Fred A. Mettler, M.D. .... Blairstown  
James A. Rogers, M.D. .... Paterson

**Medical-Surgical Plan Board of Trustees**

(Provided in MSP Bylaws)

William J. D'Elia, M.D., *President* ..... Neptune City

**Medicare Claims Inquiry Committee, Joint**

(Established by Board of Trustees 11/16/69 to provide physicians, who feel their fees have been arbitrarily reduced, or who have other bases of dissatisfaction, with a forum for discussion.)

*Representing The Medical Society of New Jersey:*

*President* — William J. D'Elia, M.D. .... Neptune City

*President-Elect* — Mathew E. Boylan, M.D. .... Jersey City

*Executive Director* — Mr. Richard I. Nevin .... Trenton

Louis F. Albright, M.D. .... Spring Lake

Donald T. Akey, M.D. .... Metuchen

*Representing the Fiscal Intermediary:*

*Vice-President* — Mr. William C. White, Jr., C.L.U.

*General Manager* — Mr. Everett J. Park, F.L.M.I.

*Associate General Manager* — Mr. Thomas J. Beatty

*Associate Director* — Mr. Wilfred I. Myers

**Medicare Law (P.L. 89-97)**

(Assigned by the Board — 10/17/65 as indicated below)  
Over-all responsibility to study and provide recommendations concerning the Medicare Program

Council on Medical Services

Consultants to the Council on Medical Services:

William J. D'Elia, M.D., *President* .. Neptune City

Mathew E. Boylan, M.D., *President-Elect* .. Jersey City

Henry J. Mineur, M.D., *Chairman,*

*Council on Legislation* ..... Cranford

Robert G. Salasin, M.D., *Chairman, Council on*

*Public Health* ..... North Wildwood

Frank J. Hughes, M.D., *Member, New Jersey Board*

*of Institutional Trustees* ..... Gloucester

**Medicare Peer Review Committee**

(Established by Board of Trustees 12/20/70 at request of fiscal intermediary. Committee will review and evaluate claims involving questions of over-utilization under Medicare. Composition of committee includes six groups of three members each in the fields of general practice, general surgery, orthopedic surgery, internal medicine, ophthalmology, and urology.

**Membership Directory**

(Special committee established by Board — 11/19/61)

Louis F. Albright, M.D., *Chairman* ..... Spring Lake

Robert C. Anderson, M.D. .... Newark

Matthew E. Boylan, M.D. .... Jersey City

Daniel B. Roth, M.D. .... Teaneck

Mr. Richard I. Nevin, *Executive Director* .... Trenton

Mr. Robert H. Lambert, *Business Manager* ... Trenton

**New Jersey College of Medicine and Dentistry, Student AMA**

(Liaison requested by New Jersey Chapter — 1/26/60)

Edward A. Wolfson, M.D. .... Glen Rock

**Nurse Pediatrician or Pediatric Nurse, Advisory Council on the**

(Liaison established by the Board of Trustees — 2/27/72 — at the request of Rutgers University)

Harold L. Colburn, Jr., M.D. .... Moorestown

**Nutrition Council, New Jersey**

(Liaison established by MSNJ — 12/19/54)

Harvey P. Einhorn, M.D. .... South Orange

**Ochampus (Office for the Civilian Health and Medical Program of the Uniformed Services)**

(1) Fiscal Agent

(Designated upon request of MSP — 7/21/63)

Medical-Surgical Plan of New Jersey

(2) Special Committee on

(Established by MSNJ — 9/9/56)

David Eckstein, M.D., *Chairman* ..... Trenton

George L. Benz, M.D. .... Newark

I. Edward Ornaf, M.D. .... Cherry Hill

**Parents and Teachers, New Jersey Congress of**

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)

William J. Farley, M.D. .... Brielle

**Peer Review Committee, State (Established at request of 1971 House of Delegates)**

1st District

George L. Benz, M.D., *Chairman* ..... Newark

Hillel M. Ben-Asher, M.D. (alternate) .... Morristown

2nd District

Thomas C. DeCecio, M.D. .... Cliffside Park

James A. Rogers, M.D. (alternate) .... Paterson

3rd District

John A. Lincoln, M.D. .... Lambertville

Karl T. Franzoni, M.D. (alternate) .... Trenton

4th District

William R. Muir, M.D. .... Mount Holly

Earl B. Keller, Jr., M.D. (alternate) .... Cherry Hill

5th District

Louis K. Collins, M.D. .... Glassboro

Sherman Garrison, M.D. (alternate) .... Bridgeton

*Consultants:*

Louis F. Albright, M.D. (MSNJ Secretary, Chairman of the Special Committee on Long Range Planning and Development, and Chairman of the Joint Ad Hoc Task Force with the New Jersey Hospital Association) ..... Spring Lake

Arthur Bernstein, M.D. (Member, Ad Hoc Task Force with the New Jersey Hospital Association) ..... Maplewood

John S. Madara, M.D. (Chairman, Judicial Council) ..... Salem

Nicholas E. Marchione, M.D. (Member, Board of Trustees, Joint Ad Hoc Task Force with the New Jersey Hospital Association, and Consultant to the Council on Medical Services) ..... Vineland

James A. Rogers, M.D. (First Vice-President of The Medical Society of New Jersey, Chairman of MSNJ Committee on Medical Education) ..... Paterson

Mr. Jack Owen, President, New Jersey Hospital Association (Member, Joint Ad Hoc Task Force with the New Jersey Hospital Association) ..... Princeton

**Pension Plan, Special Committee on**

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)

Nicholas E. Marchione, M.D., (Chairman) *Chairman of Committee on Finance and Budget* .... Vineland

William J. D'Elia, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* ..... Neptune City

Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton



**Planning and Development, Committee on Long Range**

(Established by Board of Trustees 2/21/71. The charge to this committee is to look to the future to devise policies and strategies which will improve the structure and operations of MSNJ.)

Louis F. Albright, M.D., *Chairman* . . . . . Spring Lake  
Arthur Bernstein, M.D. . . . . . Maplewood  
Nicholas A. Bertha, M.D. . . . . . Wharton  
Frederick W. Durham, M.D. . . . . . Haddonfield  
David Eckstein, M.D. . . . . . Trenton  
Karl T. Franzoni, M.D. . . . . . Trenton  
John F. Kustrup, M.D. . . . . . Trenton  
Nicholas E. Marchione, M.D. . . . . . Vineland

**Public Health Council, State Department of Health**

(Nominations for appointment by Governor requested — 9/20/64)

Harry Mickey, M.D. (appointed 6/14/71) . . . . . Maplewood

**Quackery, Committee on**

(Established at the request of the AMA — 11/15/64)

Henry J. Mineur, M.D., *Chairman* . . . . . Cranford  
Charles B. Norton, M.D. . . . . . Woodstown  
James S. Todd, M.D. . . . . . Ridgewood

**Radiation Protection Commission, Consultant to New Jersey**

(Nomination for appointment to Commission requested — 7/18/65)

Bernard M. Schnur, M.D. . . . . . Trenton

**Radiation Protection Commission, New Jersey**

(Two consultants in nuclear medicine requested by the Commission 11/66)

Frank R. Schell, M.D. . . . . . Wayne  
John J. Thompson, M.D. . . . . . Caldwell

**Widows and Orphans of Medical Men of New Jersey,  
Society for Relief of**

(Liaison requested by Society — 5/17/59)

Joseph R. Jehl, M.D. . . . . . Clifton

**Regional Planning Council, Philadelphia Medical  
Library Committee**

(Appointment of representative requested by Library Committee — 8/20/67)

Sherman Garrison, M.D. . . . . . Bridgeton

**Rehabilitation Commission, New Jersey State**

(Liaison requested by MSNJ's Committee on Rehabilitation — 5/65)

Carl A. Maxwell, M.D. . . . . . Phillipsburg

**Resolutions, Committee on Annual Meeting**

(Established, by Board of Trustees — 7/18/71 — to review all resolutions in advance of the annual meeting)

E. Vernon Davis, M.D., *Chairman* . . . . . Mount Holly  
Nicholas A. Bertha, M.D. . . . . . Wharton  
Emanuel M. Satulsky, M.D. . . . . . Elizabeth

**Safety Council, New Jersey State**

(Provided in Council Bylaws)

William J. D'Elia, M.D., *President* . . . . . Neptune City  
Delma W. Caldwell, M.D., *President's Representative* . . . . . Linden

**Selective Service System, New Jersey Chairman of Advisory  
Committee to**

(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)

Charles L. Cuniff, M.D. . . . . . Jersey City

**Welfare Council, New Jersey**

(Representative to plan meetings for annual conference on social welfare requested by Council — 5/13/66)

John J. Bedrick, M.D. . . . . . Bayonne

---

# ANNOUNCEMENTS

---

## Research Fellowships in Parkinson's Disease

The Parkinson's Disease Foundation offers research fellowships, carrying stipends up to \$750, to medical students for a period of three months. The program enables medical students interested in Parkinson's disease to work at their own or other institutions or at the Clinical Center for Parkinsonism at Columbia University Medical School under the supervi-

sion of a specified investigator.

Accompanying each application should be information concerning education, the reason for applying, the program anticipated and name of sponsor, and a letter of recommendation from the sponsor outlining the proposed work. Those interested please contact Melvin D. Yahr, M.D., Parkinson's Disease Foundation, 640 West 168th Street, New York 10032.

## Congress on Occupational Health

On September 11 and 12, the AMA's Annual Congress on Occupational Health will be held at the Drake Hotel in Chicago. Symposia, beginning at 9 a.m., will be held both days on such subjects as multiphasic health testing in industry, a registry on adverse reactions to occupational exposures, safety of nuclear reactors, aerospace medicine, group practice in occupational medicine, the occupational safety act of 1970, and the role of labor unions in occupational safety and health, with a star-studded faculty making the presentations. The program is accepted by the AAFP for twelve elective hours. There is no registration fee, and reservations may be made directly with the hotel for one of the block of rooms reserved by the AMA for those attending the Congress.

## Clinical Application of Basic Sciences

The Burlington County Memorial Hospital in Mount Holly announces the following programs for September and October, in its continuing medical education lecture series on the basic sciences and their clinical applications:

- September 14 Evaluation of Patients pre- and post-aortic coronary venous jump graft
- September 21 Atrial and Ventricular Pacemakers for Arrhythmias and Conduction Defects
- September 28 Indications, Methods, Problems in Pacemaker Management
- October 5 Heart Failure in the Elderly
- October 12 Emotional Problems of Hospitalized Patients
- October 19 Aggression and Violence
- October 26 The Battered Child

Lectures are held each Thursday at 3:30 p.m. in the Common Room of the T. J. Summey Building (160 Madison Avenue) of the Hospital. There is no charge, and the American Academy of Family Practice allows one and a half credits per session. The series is supported by an educational grant from Merck, Sharp, and Dohme. For additional information contact the Department of Medical Education, Burlington County Memorial Hospi-

tal, 175 Madison Avenue, Mount Holly. Charles J. Moloney, M.D., Acting Director.

## Symposium on Emergency Medicine

A symposium for emergency department personnel will be held on November 29 and 30 at the Cherry Hill Inn in Cherry Hill. Sponsored by the New Jersey Chapter of the American College of Emergency Physicians and the New Jersey Trauma Committee of the American College of Surgeons, the program will cover all aspects of emergency medicine. Registration fee is \$40 and application should be made to Herbert H. Butler, M.D., program chairman for the symposium, at the Underwood-Memorial Hospital, Woodbury, New Jersey 08096.

## Medical Tour in Israel—February 1973

The American Medical Association will co-sponsor, with the three principal medical institutions in Israel, a 1973 Medical Conference in Tel Aviv. Open only to AMA members, their families and guests, the 14-day trip, with 13 days in Israel, will include scientific presentations by Israeli authorities as well as visits to medical schools and medical and research facilities. Excursions are planned to Negev, Beersheba, Massada, Jerusalem, Bethlehem, Jericho, Galilee, Nazareth, Tiberias, Safed, Kibbutz, Nof Ginossar, and, of course, Tel Aviv. Women's programs will include style shows, while the scientific meetings are in session. This is all part of AMA's continued interest in the area of international health and marks the first attempt at cosponsoring a formal meeting abroad.

Albert B. Sabin, M.D., president of the Weizmann Institute of Science in Tel Aviv, is the guest host. Tour participants are scheduled to leave the U.S. on February 21, 1973, arriving in Tel Aviv the following day. Departure from Israel will be March 6. Registration for AMA members is \$50 and \$25 for relatives and physician guests. This will include the scientific meetings, a concert by the Israeli Philharmonic Orchestra, and other special features.

The Weizmann Institute will offer presentations on cancer research. Presentations on hypertension, treatment of mental diseases, heart disease, and progress in heart valve replacement will be given by the Tel Aviv University Medical School. Material on medical care, medical education, manpower, community medicine, and Israel's contribution to International Health will be offered by the Hebrew University—Hadassah Medical School. All scientific sessions will be at the Hilton Hotel in Tel Aviv.

Group travel arrangements are being coordinated by the Sentinel Travel Bureau of Chicago. Round trip group-fare New York to Israel and return will be \$873 to \$945, depend-

ing on hotel selection and the number of other stop-overs in Europe. The package includes excursions scheduled in Israel and breakfast and dinner each day on the excursion. Group-fare reductions will also apply to tickets from home to New York and return. Special side tours can be arranged.

Registration for the medical meetings in Israel should be addressed to the Department of International Medicine, American Medical Associations, 535 North Dearborn, Chicago 60610, and should be accompanied by your registration remittance (\$50 per physician and \$25 per accompanying relative or guest). A detailed program of the meetings is available upon request.

---

## OBITUARIES

---

### **Dr. John J. Brozdowski**

One of the State's senior surgeons, John J. Brozdowski, M.D., died on March 18, at the age of 78. Dr. Brozdowski received his M.D. degree at Long Island Medical College in 1919 and soon became engaged in surgical practice in Jersey City. Before retirement he was an attending surgeon at St. Francis Hospital in Jersey City. He was a member of our Hudson County Medical Society and a 1969 recipient of the MSNJ Golden Merit Award.

### **Dr. Thomas W. Connolly**

Word has just been received of the death, on January 12, 1971, of Thomas W. Connolly, M.D., a member of the Hudson County Medical Society. Dr. Connolly was born in 1890 and received his M.D. degree from Bellevue in 1913. His field of interest was otolaryngology and he practiced that specialty in Jersey

City until retirement in 1956. For many years he was a member of the attending staff at St. Francis Hospital in Jersey City. Dr. Connolly was residing in Spring Lake at the time of his death.

### **Dr. Kenneth M. Delafrange**

On July 24, at the untimely age of 59, death claimed Dr. Kenneth M. Delafrange, a graduate of Hahnemann Medical College in 1943. Dr. Delafrange was a general practitioner with special interest in cardiology. He practiced in Westwood and had been associated with the Pascack Valley Hospital, the Holy Name Hospital in Teaneck, and Hackensack Hospital. Dr. Delafrange was a member of our Bergen County component, and had been a school physician and fire surgeon in his home community. He had served as a medical officer in the Navy during World War II.

### **Dr. Ray M. Freeman**

On June 25, death came to Ray M. Freeman, M.D., a well-known Union County general



practitioner from Rahway. Dr. Freeman was a 1932 graduate of Yale Medical School and was, before retirement, an active member of the staff at Rahway Memorial Hospital. He was a Fellow of the Academy of Medicine of New Jersey and of the American Academy of Family Practice. He had served with the rank of Colonel in the Medical Corps of the Army during World War II. Dr. Freeman was 71 at the time of his death.

#### **Dr. Michael A. Marano**

Word has just been received of the death last year of Michael A. Marano, M.D. of Union City. Born in 1896, Dr. Marano was a graduate of Hahnemann Medical College, class of 1923. Known in his area of Hudson County as a general practitioner of "the old school," he had held staff appointments at North Hudson Hospital in Weehawken and at St. Mary's Hospital in Hoboken.

#### **Dr. Robert L. McKiernan**

On July 15, Robert L. McKiernan, M.D., of New Brunswick, died after a long illness. He was one of Middlesex County's oldest and best-known urologists, having formerly been chief of staff and head of his department at St. Peter's Hospital in New Brunswick, and attending urologist at Middlesex General and Roosevelt Hospitals. During the 1953 poliomyelitis epidemic he was one of those instrumental in founding the Middlesex County Polio Hospital, renamed two years later the Middlesex County Rehabilitation Hospital, now merged with the John F. Kennedy Community Hospital in Edison. Dr. McKiernan received his medical degree from Tufts in 1914. He was a Fellow of the American College of Surgeons, and a member of the American Urology Association and the New Jersey Society of Surgeons. He was a laureate of the MSNJ Golden Merit Award in 1964. Dr. McKiernan was 81 years old at the time of his death.

#### **Dr. Earle K. Miller**

Earle K. Miller, M.D., of Pennington, died suddenly at his home on July 11, at the age of 73. Dr. Miller, who received his medical de-

gree from Hahnemann Medical College in 1927, formerly practiced gynecology in Trenton, and had been on the attending staff at Helene Fuld Hospital in that city. He was a member of our Mercer County Component Medical Society.

#### **Dr. Louis L. Perkel**

On July 16, death came to Louis L. Perkel, M.D., one of Hudson County's prominent gastroenterologists. Dr. Perkel was born in 1899 and received his M.D. degree from Cornell in 1923. He was a diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians. Before retirement from private practice in Jersey City, he was on the staffs at Holy Name Hospital in Teaneck, Fair Lawn Hospital in Fair Lawn, and St. Francis Hospital and the Medical Center in Jersey City. At the time of his death, he was director of continuing education in gastroenterology at the Bergen Pines County Hospital in Paramus.

#### **Dr. William Schwartz**

One of Passaic County's senior otolaryngologists, William Schwartz, M.D., died on June 27, at the age of 74. He was graduated from the Medical School at the University of Arkansas in 1925 and was on the staff at Passaic General Hospital. Dr. Schwartz was active in civic affairs and served his home town of Passaic as police and fire surgeon. He was a member of the American Academy of Ophthalmology and Otolaryngology, the New Jersey Society of Ophthalmology and Otolaryngology, and the Academy of Medicine of New Jersey.

#### **Dr. Albert B. Shapiro**

On June 23, at the untimely age of 55, death came to Albert B. Shapiro, M.D., a well-known Cumberland County internist and cardiologist. Dr. Shapiro earned his medical degree from Georgetown University's Medical School in 1944. He was a member of the American Society of Internal Medicine and was active in the affairs of his county medical society.



Let your money grow  
on an Orange Tree

## If you are Self-Employed

Once again, Orange Savings Bank  
is first in the state with this  
unique and distinctive program  
offering outstanding benefits for  
the self-employed.

Doctors, Dentists, Lawyers, Accountants . . .

If you qualify, you can create a substantial  
nest egg for future retirement needs.

Set aside as much as \$2,500 a year, de-  
ducting it from your present taxable income,  
and pay no taxes on the earned high interest  
until you are ready to retire on your funds!

Get complete details today! Mail the coupon  
below for illustrated booklet.

### ORANGE SAVINGS BANK

Offices in Orange • Pequannock  
Hackettstown • Wyckoff • 201-676-5700

Orange Savings  
Bank's RAINBOW  
RETIREMENT PLAN  
can be the tax-saving  
POT of GOLD in  
your future!



Gentlemen: I am  
self-employed and  
want to know  
more about your  
tax-saving  
retirement plan.  
Please send me  
your free booklet.

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Main Office: Orange Savings Bank  
Main Street at Day  
Orange, New Jersey 07050

Member Federal Deposit Insurance Corporation • All deposits insured to \$20,000.

## FAIR OAKS HOSPITAL and ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

An intensive treatment mental health center with State and Joint Commission Accredita-  
tion for ages commencing with adolescence and continuing through the Medicare years.

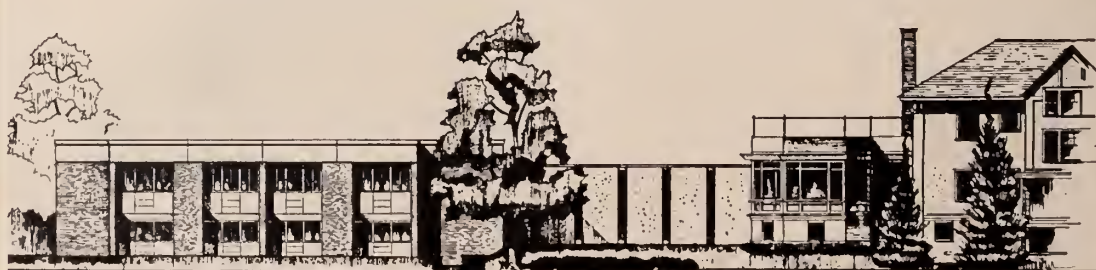
Sergio D. Estrada, M.D., Medical Director  
Oscar Rozett, M.D., Medical Administrator

Granville L. Jones, M.D., Director of Research  
Felix A. Ucko, M.D., Director, Adolescent Program

Miss M. M. Kennedy, R.N., B.S., Director, Nursing Service

Electro and Indoklon shock therapies. Insulin coma therapy. Pharmaco therapy. Individual and Group  
psychotherapy. Complete Occupational, Recreational, and Social Service Departments.

For descriptive literature write Thomas P. Prout, Jr., Administrator



---

# BOOK REVIEWS

---

**Current Diagnosis and Treatment.** Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos, California, Lange, 1972 (\$11)

No other yearly volume of diagnosis and treatment can meet the standards set by Krupp and Chatton. This is a condensed version of text-books of medicine, gynecology, obstetrics, ophthalmology, surgery, orthopedics, and nutrition.

Each subject is followed by recent references to the literature, forty for diabetes mellitus, one for the stiff-man syndrome, six for familial periodic paralysis, all dating from 1965 to 1971.

Tables are numerous, condensing to a quick and easily assimilable form such topics as infections and the choice of antibiotics, the types of hyperlipidemia and their treatment, and the endocrine hormones and their sites of action.

Psychiatric disorders, alcoholism, drug abuse, and sexual deviations are all briefly surveyed. There are chapters on medical genetics, poisons, and malignant disorders. There is an appendix with a section on interpretation of laboratory results. The index is not skimpy.

The Goeckerman and the Ingham methods of treating psoriasis are mentioned but not explained; they should be. The differential diagnosis of abdominal pain makes no mention of parietal neuralgia, but then, what text does?

If there was only one book the family physician had to refer to, it should be this.

Sidney Friedenberg, M.D.

**A Decade of Progress. The United States Medical Department, 1959 to 1969.** Office of the Surgeon General. Department of the Army, Washington, 1971. Pp. 214 (\$2.25)

This absorbing little book could have been entitled, "Advances of the United States Medical Department under the Leadership of Surgeon General Leonard D. Heaton." The General attained pre-eminence not only as one of the most outstanding surgeons general, but also as one of our most prominent clinicians. General Heaton was appointed the Surgeon General by President Eisenhower in 1959, and in an unprecedented move, President Kennedy reappointed him to a second term, and President Johnson also broke precedent by extending his term to 1969. Under General Heaton's leadership, the medical and surgical services in United States military hospitals kept pace with parallel services in civilian hospitals. For example, in 1960 several military hospitals progressively expanded their capabilities to perform cardiac catheterization and open-heart surgery. Sixteen new hospitals equipped with the most modern equipment were constructed during this ten-year period.

The Medical Department has promptly and efficiently provided medical support to military crises and mercy missions, including the Cuban and Dominican affairs, and the Chilean, Yugoslavian, and Alaskan earthquakes. In the expanding Vietnam war, surface evacuation was impractical and air evacuation by helicopter was the innovation that solved the problem of bringing the wounded quickly to medical installations for definitive treatment.

All these interesting facts and others relating to the career of General Heaton and the activities of the Medical Department during this decade are briefly discussed and provide a pocket-sized fountain of information.

Henry A. Brodtkin, M.D.

**The Pediatric Nurse Practitioner,** Fernando J. deCastro, M.D. and Ursula T. Rolfe, M.D. St. Louis, Mosby, 1971. Pp. 154. (\$6.50)

According to the authors, this manual is offered as an outline to allow nurses to expand their empirical knowledge of ambulatory pediatrics; as a guide for recent pediatric nurse practitioner graduates; and as a reference for public health nurses, and nurses working in a doctor's office who never received formal training but function as nurse practitioners. The text is divided into three sections: health appraisal, clinical problems, and social problems. The chapters are brief and deal with the physical examination, history, growth and development, immunizations, emergencies, pharmacology, skin, and so on.

For a 154-page book, the authors are trying to take a gigantic bite. It is much too incomplete to be used as a reference book and the intent can be better performed by any of the standard textbooks on pediatrics. As an example, one paragraph describes the eye-ground examination and another describes epistaxis management; both are inadequate. A book of this nature should have placed more stress on when to seek more experienced help. Instead, I wonder if this review should have been done by a nurse practitioner rather than a pediatrician who has had 25 years for his bias not only to jell but to harden.

Albert P. Rosen, M.D.

**Cardiovascular Physiology.** Edition 2. Robert M. Berne, M.D. and Matthew N. Levy, M.D. St. Louis, Mosby, 1972. Pp. 265. Illustrated. (\$9.25)

As stated by the authors, "This book is designed primarily for medical students . . . to emphasize general concepts and to ignore isolated facts. . . ."

This delightful textbook is well written, covering all the important topics about CV physiology. The meanings and language are clear, precise, and simple. The diagrams are brilliantly simplified to emphasize concept and clarity, and to avoid confusing detail. The book is a standard in medical schools and would be helpful also for the practitioner who never learned the subject, and for the specialist who wants to fill in the gaps and brush up on basics.

Although only 252 pages, the book reads slowly and will not serve as a quick review. It is highly recommended as an authoritative, well-organized text on a major subject in medicine, crammed with new data and ideas that have revolutionized the field.

Though of recent vintage, this reviewer found much to learn here.

Norman Riegel, M.D.



**EMERGENCY ROOM PHYSICIANS**, New Jersey license required. Excellent salary & full benefits; 234-bed general short-term community hospital located in family shore resort community, with water sports & hunting in season. Within an hour's drive of large cultural center; 22,000 emergency room visits annually. Write or telephone Mr. William M. Jenkins, Administrator, Shore Memorial Hospital, Somers Point, N. J. 08244. 609-927-3501.

## **NEW JERSEY**

**FULL TIME** **PART TIME**

**EMERGENCY ROOM**

**VARIED SHIFTS AVAILABLE**

**NEW JERSEY LICENSE REQUIRED**

APPLY: R. J. Matthews, Personnel Director, Point Pleasant Hospital, Osborn Avenue and River Front, Pt. Pleasant, N.J. 08742  
Phone (201) 892-1100

## **INDUSTRIAL CLINIC PHYSICIAN**

Wanted for northern N. J. Clinic. Full or part time. Normal work hours—no weekends. Liberal benefits. Submit resume to: Box No. 23, c/o THE JOURNAL.

## **INTERNS NEEDED**

General Practice for 87-bed fully accredited community hospital in Southern New Jersey. E.C.F.M.G. Certificate—\$17,000—Blue Cross/Blue Shield—Midway Philadelphia—Atlantic City 30 minutes away—Opening immediately. Send full particulars to Box No. 21, c/o THE JOURNAL.

## **MEDICAL DIRECTOR**

**EMERGENCY ROOM—FULL TIME**

Experience preferred but not essential. Expanding central N.J. Hospital—approved intern and residency programs. Salary \$45,000 annually plus benefits. Send resume to: Box No. 24, c/o THE JOURNAL.

## **OBSTETRICIAN-GYNECOLOGIST**

Board certified or eligible to do minor surgical procedures one day a week. Pennsylvania license required. Write Box No. 27, c/o THE JOURNAL, P.O. Box 904, Trenton, N.J. 08605

## **PART-TIME PHYSICIANS**

In Ophthalmology, Orthopedics and Urology. Excellent opportunity for retiring Physicians and recent residency graduates. Write:

**Chief, Outpatient Clinic**  
**Veterans Administration**  
**20 Washington Place**  
**Newark, N.J. 07102**

**Phone: (201) 645-3430**

## **PART-TIME PHYSICIAN**

Jersey licensed physician for Planned Parenthood clinic located at 174 Brower Avenue, Edison, New Jersey. Ob-Gyn preferred. \$25/hour. Call (201) 225-2777 or write: Planned Parenthood, 174 Brower Avenue, Edison, New Jersey 08817.

# CLASSIFIED ADVERTISEMENTS

**GENERAL INTERNIST**—Or Cardiologist, certified or board eligible for busy certified internist. Salary initially, partnership later. Suburban practice. Newark fringe. 600 bed hospital. Write Box no. 25, c/o THE JOURNAL.

**GENERAL PRACTITIONER WANTED**—To practice afternoons and assume hospital work. No investment, immediate income. Bayshore town in Monmouth County. Write Box No. 15, c/o THE JOURNAL.

**INTERNIST**—Subspecialty Renal diseases, seeks partnership, group or hospital position in New Jersey. M. Rahman, M.D., 275 Bay 37 Street, Brooklyn, New York, 11214 or call (212) 996-5202.

**RADIOLOGIST**—Board certified, desires part time position in hospital private office or medical clinic. Cherry Hill and adjacent area. 4 mornings a week. Write Box No. 26, c/o THE JOURNAL.

**UROLOGY**—Board eligible, military service completed, available July, 1973. Franklin A. Morrow, M.D., 1 Wall Street, Fort Lee, New Jersey 07024. Phone (201) 944-8380.

## Patronize Our Advertisers

**Information for Advertisers—RATES:**—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifth of preceding month.

## ADDITIONAL PERSONNEL SEE PAGE 802 (OVER)

### COLLECTIONS

#### HENRY-LESLIE ASSOCIATES

"BONDED"

P.O. BOX A

CRANBURY, N. J. 08512

(609) 395-1760

P.O. BOX 905

TOMS RIVER, N.J. 08753

(201) 244-2502

*Professional Services for the Health Professions*

**NO CHARGE UNLESS WE COLLECT**

### FOR SALE—BERGEN COUNTY

Ex Friary—14 rooms. Brick and aluminum. Excellent condition, excellent parking. Suitable for doctor's offices &/or residence in town without M.D. \$80,000.

Five minutes from Valley Hospital in Ridgewood. 150 ft. frontage on recently widened road. Includes 7 rm house with pool on over an acre of land. Beautiful setting. Ideal for professional offices and/or residence. \$115,000. Owner take back mortgage.

**McNERNEY-TALMO REALTY, INC.**

River Edge, N. J.

(201) 261-7654 Investment Dept.

**PHYSICIANS WANTED:** Psychiatrist—Immediate openings to work on Psychiatric Services. Also openings in community mental health clinics in need of expansion. Jersey Shore Area. Excellent personnel programs and benefits. May have part time practice. State License required. Salary to \$29,714.00 depending on qualifications. Send resume in confidence to Michael R. Simon, M.D., Medical Director, Marlboro Psychiatric Hospital, Marlboro, New Jersey. Telephone: 201-946-8100.

### WANTED

Partner in established Family Practice, suburban New Jersey. Will also participate in development, administration and teaching of Family Practice Residency Program at 550-bed hospital. Write Box No. 20, c/o THE JOURNAL.

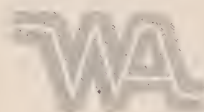
## PHYSICIANS

### Interested in Pharmaceutical Research

We have a number of interesting positions available with major pharmaceutical companies in eastern, mid-western, and western locations.

Current research efforts include cancer chemotherapy, rheumatic diseases, cardiology, dermatology, contraceptive and psychotropic products. Prior experience in these areas of research is desirable but not essential. Salaries are based on training and experience. All fees are paid by our client companies.

Send your curriculum vitae, geographic preference, and salary requirements in confidence to:



**WATSON ASSOCIATES**  
EXECUTIVE SEARCH SPECIALISTS

34 SOUTH BROADWAY,  
WHITE PLAINS, NEW YORK 10601  
(914)-428-7322

Tired of the city rat-race?

Worried about the safety and health of your family?

Your future may lie in beautiful Sussex County with its great ski areas, resorts, lakes, farms, woodlands and residential areas.

We have just completed an ultra-modern 117-bed general hospital in this rapidly growing area. There is an urgent need in the community for:

General Practitioners  
Urologists  
Eye, Ear, Nose and Throat  
Cardiologist  
Pediatrician

If you are interested in enjoying the many benefits of this fine community, call or write:

**Kenneth E. Meredith**  
Administrator  
Alexander Linn Hospital  
Sussex, New Jersey 07461  
201-875-4121

## THE MEDICAL SOCIETY OF NEW JERSEY

### Professional Liability Insurance Program

#### Society Endorsed Coverages—

- Professional Liability for  
Individuals  
Partnerships and Professional Corporations  
Employed Nurses, Technicians or Aides
- Professional Premises
- Excess (Umbrella) Liability—Limits up to \$5 Million

#### Management of Loss Control Program—

- Claims Peer Review
- Prompt Advice Regarding Potential or Actual Claims
- Defense by Highly Skilled and Experienced Counsel
- Investigation by Specialists in Malpractice

## JOSEPH A. BRITTON AGENCY

15 South Munn Ave., East Orange, N.J. 07018  
(201) • 673-3060



TEMPLE UNIVERSITY HEALTH SCIENCES CENTER presents the 16th Annual Postgraduate Course, Recent Advances in Medicine, on 8 consecutive Wednesday's from October 18 to December 6, 1972 from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand Rounds, Clinics, Case Discussions, Office Procedures, Lectures, Panel Discussions, Luncheon with the Experts, all with audience participation.

Faculty: Members of the Department of Medicine and other selected Departments of Temple University Health Sciences Center.

Guest Faculty:

Grant Liddle, M.D.  
Professor and Chairman,  
Department of Medicine  
Vanderbilt University School of Medicine  
Nashville, Tenn.

Henry D. McIntosh, M.D.  
Professor and Chairman,  
Department of Medicine  
Baylor University School of Medicine  
Houston, Texas

Frank A. Finnerty, Jr., M.D.  
Professor of Medicine  
Georgetown University Medical Center  
Washington, D. C.

James L. Quinn, III, M.D.  
Professor of Radiology  
Northwestern University Medical School  
Chicago, Ill.

A.A.G.P. Credit Requested

For further information and Curriculum: Department of Medicine  
Temple University Health Sciences Center  
3401 North Broad Street  
Philadelphia, Pennsylvania 19140  
Sol Sherry, M.D.  
Chairman, Department of Medicine  
Albert J. Finestone, M.D.  
Director of Course

**Symposium on Peripheral Arterial Disease**  
**Current Concepts of Diagnosis, Medical and Surgical Treatment, Prosthetic Applications**  
**Friday, October 27 and Saturday, October 28, 1972**  
**Temple University Health Sciences Center**  
**Department of Rehabilitation Medicine and Rehabilitation Research and Training Center**

Location of course and accommodations: Temple University Conference Center,  
9230 Germantown Avenue, Philadelphia, Pennsylvania (Chestnut Hill Area)

A comprehensive two-day symposium on pathophysiology of altered hemodynamics, intravascular thrombosis, and arterial degeneration. Current and advanced techniques of: diagnosis, medical and surgical treatment, comprehensive consideration of lower extremity, amputation techniques, immediate post-operative and standard prosthetic techniques and recent prosthetic advances with their neurophysiological implications. Guest Faculty consisting of nationally recognized authorities.

Course Credits: Applied for Pennsylvania and AMA Academy of Family Physicians

Registration limited to 150—Physicians \$100.00, Residents: \$50.00

Overnight accommodations available—Room and meals included.

(Meals only: Lunch—\$5.00, Dinner—\$8.00)

Double Occupancy: \$30.00 (meals included)

Single Occupancy: \$37.00 " "

Inquiries: Department of Rehabilitation Medicine, Temple University Health Sciences Center,  
3400 North Broad Street, Philadelphia, Pennsylvania 19140  
Phone: 215-221-3636.

# Will his return to work mean the return of undue psychic tension?



When it's mandatory to keep the post-coronary patient calm, consider Valium (diazepam).

Although he's promised to take it easy back on the job, you know he's going back to the same stressful circumstances that may have contributed to his hospitalization. If he experiences excessive anxiety and tension because of overreaction to stress, your prescription for Valium can bring relief. During the period of readjustment Valium can quiet undue anxiety.

For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *b.i.d.* to *q.i.d.* can usually provide reliable relief. For severe tension/anxiety

states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

## Valium® (diazepam)

For the tense cardiac patient who must be kept calm

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as hyperexcited states, anxiety, irritations, increased muscle spasm, insomnia, rage, sleep disturbance have been reported; these occur, discontinue drug. Reports of neutropenia, jaund, periodic blood counts and liver tests advisable during long-term therapy.

**Dosage:** Individualize for beneficial effect. **Adults:** Ten: and psychoneurotic states, 2 b.i.d. to q.i.d.; alcoholism, 10 or q.i.d. in first 24 hours, then 10 or q.i.d. as needed; adjunctive skeletal muscle spasm, 2 to 10 or q.i.d.; adjunctively in convulsions, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2½ mg, 1 or 2 times daily increasing as needed and tolerated (See Precautions.) **Children:** t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

ROCHE

Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

LIBRARY

SEP 18 1972

NEW YORK ACADEMY  
OF MEDICINE

2 East 105th Street  
New York, New York 10029 C

the

## JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

## contents

Pages 803 to 896



## EDITORIALS

Inconsistent Health Insurance Programs	815
Long Distance Cardiac Diagnosis	815
A Billion for Proprietaries	816
Learning by the Mistakes of Others	816

## ORIGINAL ARTICLES

Histopathology of Granulomatous Diseases of the Chest Edward Wagman, M.D., Paramus	817
Ethnic Isolation and the Bilingual Patient Julio C. DelCastillo, M.D., Trenton	826
Common Anorectal Problems Dave B. Swerdlow, M.D., Glen Ridge	835
Physiologic Basis of Training and Conditioning of Athletes Max M. Novich, M.D., Perth Amboy	841
Multiple Myeloma with Myeloid Metaplasia Norman D. Corwin, M.D., Westwood	847
New Challenges to Medical Care James A. Rogers, M.D., Paterson	855

## SPECIAL ARTICLE

Talking Pictures for Patient Contact Jack Adams-Ray, M.D., Stockholm, Sweden, and Fradley H. Garner, Vedback, Denmark	859
---	-----

## NEW JERSEY DOCTORS' NOTEBOOK

Eye Health Screening: Medical Society's Experience	873
Communicable Diseases in New Jersey	878
Medical College Notes	879
Physicians Seeking Location in New Jersey	880

ANNOUNCEMENTS	881
MEETINGS OF MEDICAL INTEREST	883
LETTERS TO THE JOURNAL	886
OBITUARIES	887
BOOK REVIEWS	893

OCTOBER 1972  
VOL. 69, NO. 10



# THE MEDICAL SOCIETY OF NEW JERSEY

## Endorsed Insurance Plans

### ACCIDENT AND HEALTH INSURANCE

**\$1,200** a month maximum BASIC total disability benefit.  
Accident: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)  
↓  
**PLUS** Sickness: from 8th day, up to 2 years  
Accident: may be EXTENDED to Lifetime  
Sickness: may be EXTENDED to 7 years  
↓  
**\$1,000** a month maximum NEW LONG-TERM PLAN.  
Payable up to Lifetime for accident—Age 65 for sickness  
Choice of waiting periods:  
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

★ ★ ★

### LIFE INSURANCE

**\$10,000 to \$150,000** of Convertible Term Life Insurance  
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)

**\$10,000 to \$50,000** of Convertible Term Life Insurance  
available for spouse, dependent children and employees.

★ ★ ★

### MAJOR EXPENSE INSURANCE

**\$25,000** maximum for Covered Expenses as stated in the policy for each accident or sickness, covering member, spouse, and eligible children. \$750 deductible, 20% co-insurance. (Physicians' and surgeons' fees are not a Covered Expense.)

★ ★ ★

### HOSPITAL-MONEY PLAN

**\$20-\$30-\$40** per day paid for each day that you or your dependents are hospitalized, from the first day for as long as 365 days for any one accident or sickness. Benefits are tax-free.

★ ★ ★

### SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

**\$200,000** maximum for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance. **\$100,000** maximum for spouse (without disability benefit).

★ ★ ★

H.R. 10 (KEOGH) RETIREMENT PLAN ★ ★ CORPORATE MASTER PLAN

#### APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected or have applied for membership.

*Information and claim service are as close as your telephone.*

**E. & W. BLANKSTEEN AGENCY, INC.**

75 MONTGOMERY STREET, JERSEY CITY, NEW JERSEY 07302

(201) DElaware 3-4340

Announcing—  
a new commitment to health care

# Roche Clinical Laboratories

Professional  
Consultation

An Advanced  
Diagnostic Center for  
Standard, Endocrine  
and Special Laboratory  
Tests

Computerized  
Quality Control  
to prevent error

Automated Diagnostic Analysis  
for most tests

Personal Service through Roche Professional Representatives.

A Unique Professional  
Staff of Research  
Scientists and Practicing  
Clinicians

The Roche Professional Representative welcomes the opportunity to introduce our laboratory service to you.  
Please fill in the coupon below for additional information.

ROCHE

Roche Clinical Laboratories, Inc.  
1 Fairfield Crescent, West Caldwell, New Jersey 07006

Gentlemen:  
I am interested in learning more about  
Roche Clinical Laboratories' Services.

- ☐ Please send the Roche Clinical Laboratories  
Reference Manual.
- ☐ Please have a Roche Professional Representative  
contact me.

Name \_\_\_\_\_

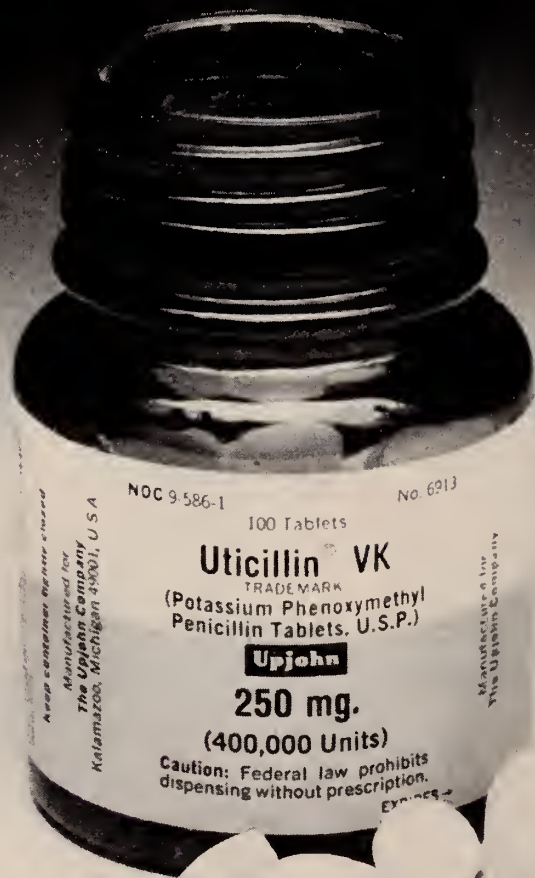
Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Tel. No. \_\_\_\_\_



# Upjohn's low-priced penicillin VK



## Uticillin<sup>®</sup> VK

(potassium phenoxyethyl penicillin, U.S.P., Upjohn)

Available in 250 and 500 mg tablets;  
250 mg/5 ml and 125 mg/5 ml flavored granules  
for oral suspension

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2144-6



# Look what comes with your Rossmoor home.



## Your own 18-hole par-71 course!

Imagine having an 18-hole, par-71 course with PGA pro right in the community were you live. Within walking distance of your home. Where you can play as frequently as you wish without fighting your way through miserable traffic; without interminable delays waiting to tee off. At a nominal yearly fee that's only a tiny fraction of the cost of joining a golf or country club.

That's the wonderful world of Rossmoor. Designed for active adults 48 years and over, retired or not.

But golf isn't the only attraction in this unique community. There's

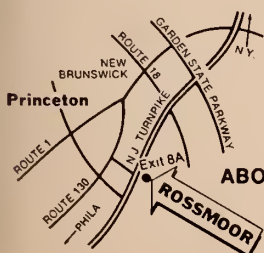
tennis. And swimming in an olympic-size pool. And so many other recreation activities, you'd need a 10-day week to fit them all in.

The real beauty of living at Rossmoor is that you have more time to enjoy all these pleasures. Though you have all the tax advantages and equity build-up that comes with home ownership, you have none of the chores. All the exterior work is done for you here. A trained staff fertilizes, limes and mows your lawn, rakes the leaves, shovels the snow and maintains the exterior of your home.

You also have perfect peace of mind here because Rossmoor is a protected community. With a gateman and a roving security force that protects you 24 hours a day.

If you think it costs a fortune to live here, we have great news for you. The condominium manor homes with 2 bedrooms and 2 baths, G. E. appliances and central air conditioning are priced from \$27,650.

Come live where all the active adults live. At Rossmoor. Where the 19th hole more than likely will be located on your own patio.



*The adult community for active people.*  
**Rossmoor**  
 Monroe Township, N.J. / (609) 655 2270  
 AT EXIT 8A OF THE NEW JERSEY TURNPIKE



Sponsored and developed by  
 GUARDIAN DEVELOPMENT CORP., a publicly-owned company.

# THE MEDICAL SOCIETY OF NEW JERSEY

*Founded July 23, 1766*

## Officers and Trustees

<b>PRESIDENT</b>	William J. D'Elia, M.D. (Monmouth) . . . . . Neptune City
<b>PRESIDENT-ELECT</b>	Matthew E. Boylan, M.D. (Hudson) . . . . . Jersey City
<b>FIRST VICE-PRESIDENT</b>	James A. Rogers, M.D. (Passaic) . . . . . Paterson
<b>SECOND VICE-PRESIDENT</b>	John J. McGuire, M.D. (Essex) . . . . . Newark
<b>IMMEDIATE PAST-PRESIDENT</b>	E. Vernon Davis, M.D. (Burlington) . . . . . Mount Holly
<b>SECRETARY</b>	Louis F. Albright, M.D. (Monmouth) . . . . . Spring Lake
<b>TREASURER</b>	Samuel J. Lloyd, M.D. (Mercer) . . . . . Trenton

## Trustees

<b>CHAIRMAN</b>	A. Guy Campo, M.D. (1973) (Gloucester) . . . . . Westville
<b>SECRETARY</b>	David Eckstein, M.D. (1975) (Mercer) . . . . . Trenton
	Robert C. Anderson, M.D. (1975) (Essex) . . . . . Newark
	Francis J. Benz, M.D. (1973) (Morris) . . . . . Chatham
	George L. Benz, M.D. (1974) (Essex) . . . . . Newark
	Edward J. Bourns, M.D. (1975) (Union) . . . . . Westfield
	Harold L. Colburn, Jr., M.D. (1973) (Burlington) . . . . . Mount Holly
	Charles L. Cuniff, M.D. (1975) (Hudson) . . . . . Jersey City
	Richard E. Lang, M.D. (1975) (Passaic) . . . . . Passaic
	Nicholas E. Marchione, M.D. (1974) (Cumberland) . . . . . Vineland
	I. Edward Orna, M.D. (1975) (Camden) . . . . . Camden
	Howard D. Slobodien, M.D. (1975) (Middlesex) . . . . . Perth Amboy
	James S. Todd, M.D. (1974) (Bergen) . . . . . Ridgewood

## Councilors

<b>FIRST DISTRICT</b> (Essex, Morris, Union, and Warren Counties)	Thomas S. P. Fitch, M.D. . . . . Plainfield (1975)
<b>SECOND DISTRICT</b> (Bergen, Hudson, Passaic, and Sussex Counties)	John L. Olpp, M.D. . . . . Englewood (1974)
<b>THIRD DISTRICT</b> (Hunterdon, Mercer, Middlesex, and Somerset Counties)	Albert F. Moriconi, M.D. . . . . Trenton (1973)
<b>FOURTH DISTRICT</b> (Burlington, Camden, Monmouth, and Ocean Counties)	Frederick W. Durham, M.D. . . . . Haddonfield (1975)
<b>FIFTH DISTRICT</b> (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)	John S. Madara, M.D. . . . . Salem (1974)

## AMA Delegates

Joseph P. Donnelly, M.D. (1973)	Jersey City
Frank J. Hughes, M.D. (1974)	Gloucester
John E. Kustrup, M.D. (1974)	Trenton
Luke A. Mulligan, M.D. (1974)	Leonia
Isaac N. Patterson, M.D. (1973)	Westville
Emanuel M. Satulsky, M.D. (1974)	Elizabeth



October 1972

## Publication Committee

Daniel B. Roth, M.D., *Chairman*  
Arthur Krosnick, M.D.  
John F. Marshall, M.D.

## Editor

Henry A. Davidson, M.D.

## Assistant Editor

Marjorie D. Treptow

## Advertising Manager

Joseph W. Cookson

## Executive Director

Richard I. Nevin

*The Journal* is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 818.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription (\$3.50) is included in the dues of Society members.

Subscription rates for nonmembers: \$7 per year (including postage), in advance. Outside USA, postage is additional.

Single copies are \$1.00 each.

Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

Second class postage paid at Trenton, New Jersey, and additional entry office.

Copyright 1972 by The Medical Society of New Jersey.





## rheumatoid arthritic blowup ...

### **Tandearil**<sup>®</sup> Geigy

oxyphenbutazone NF      tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is

unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal

distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B) 98-146-800-E

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardley, New York 10502





# a new outlook in chronic pain

of moderate to severe intensity

Though Talwin® Tablets, brand of pentazocine (as hydrochloride), can be compared to codeine in analgesic efficacy, Talwin is not subject to narcotic controls. Patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with meperidine or codeine. And that, in the long run, can mean a better outlook for your chronic-pain patient.

#### Talwin Tablets are:

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe — day or night — even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, light-headedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

**Talwin®**

brand of

**pentazocine**

(as hydrochloride)

the long-range analgesic



# a new outlook in chronic pain

of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

**Usage in Pregnancy.** Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

**Drug Dependence.** There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

**Acute CNS Manifestations.** Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

**Usage in Children.** Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Ambulatory Patients.** Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

*Myocardial Infarction.* As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

*Biliary Surgery.* Until further experience is gained with the effects

of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract. *Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

**CNS Effect.** Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

**Children Under 12 Years of Age.** Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Duration of Therapy.** Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

**Treatment.** Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are not effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®) may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

**Winthrop** Winthrop Laboratories, New York, N. Y. 10016 (1583)

50 mg. Tablets

**Talwin®**  
brand of  
**pentazocine** (as hydrochloride)

the long-range analgesic





Let your money grow  
on an Orange Tree

## If you are Self-Employed

Once again, Orange Savings Bank  
is first in the state with this  
unique and distinctive program  
offering outstanding benefits for  
the self-employed.

Doctors, Dentists, Lawyers, Accountants . . .

If you qualify, you can create a substantial  
nest egg for future retirement needs.

Set aside as much as \$2,500 a year, de-  
ducting it from your present taxable income,  
and pay no taxes on the earned high interest  
until you are ready to retire on your funds!

Get complete details today! Mail the coupon  
below for illustrated booklet.

## ORANGE SAVINGS BANK

Offices in Orange • Pequannock  
Hackettstown • Wyckoff • 201-676-5700

Orange Savings  
Bank's RAINBOW  
RETIREMENT PLAN  
can be the tax-saving  
POT of GOLD in  
your future!



Gentlemen: I am  
self-employed and  
want to know  
more about your  
tax-saving  
retirement plan.  
Please send me  
your free booklet.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Main Office: Orange Savings Bank  
Main Street at Day  
Orange, New Jersey 07050

Member Federal Deposit Insurance Corporation • All deposits insured to \$20,000.

## The treatment of impotence

due to androgenic deficiency in the American male.  
The concept of chemotherapy plus the  
physician's psychological support is confirmed  
as effective therapy.

NEW  
CLINICAL  
STUDY

The Treatment of Impotence  
with Methyltestosterone Thyroid  
(100 patients—Double Blind Study)  
T. Jakobovits  
Fertility and Sterility, January 1970  
Official Journal of the  
American Fertility Society

## Android<sup>®</sup>

(thyroid-androgen) tablets



### Double-Blind Study and Type of Patient:

100 patients suffering from impotence. Of  
the patients receiving the active medication  
(Android) a favourable response was seen  
in 78%. This compares with 40% on  
placebo. Although psychotherapy is indi-  
cated in patients suffering from functional  
impotence the concomitant role of chemo-  
therapy (Android) cannot be disputed.

### Choice of 4 strengths:

#### Android

Each yellow tablet contains:  
Methyl Testosterone . . .2.5 mg.  
Thyroid Est. (1/6 gr.) . . .10 mg.  
Glutamic Acid . . . . .50 mg.  
Thiamine HCL . . . . .10 mg.  
Dose: 1 tablet 3 times daily.  
Available:  
Bottles of 100, 500, 1000.



#### Android-HP

HIGH POTENCY

Each red tablet contains:  
Methyl Testosterone . . .5.0 mg.  
Thyroid Est. (1/3 gr.) . . .20 mg.  
Glutamic Acid . . . . .50 mg.  
Thiamine HCL . . . . .10 mg.  
Dose: 1 tablet 3 times daily.  
Available:  
Bottles of 100, 500, 1000.

#### Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:  
Methyl Testosterone . . .12.5 mg.  
Thyroid Est. (1 gr.) . . .40 mg.  
Glutamic Acid . . . . .50 mg.  
Thiamine HCL . . . . .10 mg.  
Dose: 1 or 2 tablets daily.  
Available:  
Bottles of 60, 500.

#### Android-Plus

WITH HIGH POTENCY  
B-COMPLEX AND VITAMIN C

Each white tablet contains:  
Methyl Testosterone . . .2.5 mg.  
Thyroid Est. (1/6 gr.) . . .15 mg.  
Ascorbic Acid (Vit. C) . . .250 mg.  
Thiamine HCL . . . . .25 mg.  
Glutamic Acid . . . . .100 mg.  
Pyridoxine HCL . . . . .5 mg.  
Niacinamide . . . . .75 mg.  
Calcium Pantothenate . . .10 mg.  
Vitamin B-12 . . . . .2.5 mcg.  
Riboflavin . . . . .5 mg.  
Dose: 2 tablets daily.  
Available: Bottles of 60, 500.

**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, tachycardia, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montesano, P. and Evangelista, J. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tizabi, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Haiman, L., Braslow, M. L., Zimaff, E., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interactions and the hypohypothalamic effect of androstenedione. J Clin Endoc 19:338, 1959. 5. Farris, E. J., and Caltan, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 78:653, 1958. 6. Oski, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tcl-E-Dose® packages of 1000.

# Valium® (diazepam)

To help you manage excessive psychic tension





**Not too little, not too much...  
but just right!**

"Just right" amounts of Ilosone Liquid 250  
can be dispensed easily from the pint bottle in *any* quantity  
you specify to meet your patients' precise needs—  
without regard to package size.

ready-mixed **Ilosone Liquid 250**

Erythromycin Estolate

(equivalent to 250 mg of base per 5-ml teaspoonful)

*Additional information available  
to the profession on request.  
Eli Lilly and Company  
Indianapolis, Indiana 46206*



100204

---

# EDITORIALS

---

## Inconsistent Health Insurance Programs

In this highly political year, it has almost become SOP to promise all kinds of goodies, dismissing internal consistency as the hobgoblin of small minds.\*

A June 30, 1972 release from the AMA's Washington office includes some extracts from the platform committee's recommendations made at a national political convention held in July. After proposing a system of compulsory health insurance coverage, the committee recommended one that protected the rule of free choice, which would seem to be inconsistent with the emphasis on the "compulsion." They urged "incentives to bring health personnel back to inner cities," but offered no consistent program for doing that. They urged "generic labeling of equal-effective drugs." They wanted to make staff-patient ratios in VA hospitals comparable to the figures in community hospitals, but no blueprint was provided. They wanted the VA to "assume responsibility for the care of the wives and children of veterans who were disabled by or had died of service-connected causes." On the other hand, they sternly warned that the "federal government should not operate the various elements of the health care system," though how the government would pay off on all these promises without a dynamic role in "operating" the system is not clear.

If not for consistency, at least an "A" for effort!

## Long Distance Cardiac Diagnosis

Electronic perfection has reached a new high in the development and practical demonstration of a device which can relay the electro-

cardiographic components of a patient's heart-beat thousands of miles and be received by telephone.

The demonstration took place recently at Stanford University, where a patient's electrocardiogram was relayed from Stanford to Manila, where the signal was bounced off a synchronous satellite over the Pacific back to Stanford. The electrocardiogram was received by telephone in the same room with the patient after the signal had traveled 51,000 miles. There was no distortion and a direct recording of the patient's electrocardiogram made immediately matched exactly with the one transmitted.

This opens up tremendous possibilities. It is suspected that approximately 150,000 people in this country die suddenly each year from heart attacks before reaching medical aid. It is also strongly suspected that arrhythmias unnoticed by the patient may precede by some days the fatal heart attack. To clear up these suspicions a group of high-risk patients are being studied at Stanford by means of several different types of monitoring devices to determine the incidence of arrhythmia among them. The effect on mortality of correction of the arrhythmias by appropriate drug therapy will also be studied.

The most interesting monitoring device being used is one which weighs five and one-half ounces, is the size of a cigaret case, and is strapped to the patient's chest by two electrodes. When an abnormal rhythm occurs the instrument sounds a warning beep. The patient calls his physician who, having a prior electrocardiogram before him, asks the patient to record. The patient places the telephone receiver next to the device and pushes a button to activate it. The physician places his telephone receiver on top of a console the size of a table radio and receives immediately a printout of the patient's current electrocardio-

---

\* Actually the way Ralph Waldo Emerson put it was, "A foolish consistency is the hobgoblin of little minds, adored by little statesmen and philosophers and divines."

gram. The transmission lasts forty seconds and can be repeated as often as desired.

This medical DEW line, now on this side of the horizon, could effectively alter the mortality statistics of heart disease.

From the April 15, 1972 New York State Journal of Medicine.

## A Billion for the Proprietaries

The Food and Drug Administration has recently announced its intention to review over-the-counter medications distributed without physicians' requests. We learn from the release that in 1969, manufacturers grossed a billion dollars from the sale of proprietary self-prescribed medications. The advertising expenses (mostly on television) amounted to \$24,000,000 for Anacin, \$19,000,000 for Alka-Seltzer, \$14,500,000 for Dristan, and \$13,900,000 for Bufferin. Commissioner Edwards explained that everyone cannot or "should not go to a doctor, so that self-treatment is essential to the nation's health." At the same press conference, Dr. Edwards reported that in a review of proprietary medications by the National Academy of Sciences, "only 25 per cent were classifiable as effective." This figure also appeared in a January 1972 issue of the *Federal Register*. The regulation of advertising to the general public is in the hands of the Federal Trade Commission, not the FDA. The FDA does have responsibility for promotion of drugs to physicians. In the FDA's plan for reviewing efficacy of over-the-counter drugs sold to the public, first priority will be to antacids, second to mood-influencing drugs, and third to anodynes.

One of the brightest pages in the history of the AMA has been in its long campaign against nostrums. This had been undertaken not to preserve a monopoly for medical practitioners, but out of a genuine concern about protection of the public's health. With three out of four of the widely promoted proprie-

taries being classed as "not effective," this would certainly seem to be a legitimate field of our professional interest. One cannot but help feel that the millions spent for promoting non-prescription pain-killers or cold remedies could find a socially more useful outlet.

## Learning by the Mistakes of Others

He who does not heed history's warnings may live to regret it, for history has recorded events that serve as sort of an intellectual bank from which we may draw in our thinking and planning and in the execution of our affairs.

In medicine, the doctor's prime concern is not simply to diagnose disease and to treat patients with disease; his number one concern is total patient care. He must be the prime mover in this direction.

Let us consider this goal very seriously. If we do not, it will greatly affect the delivery of health care, which is our basic responsibility. We must be aware of the rapid changes we are experiencing. These changes have been brought about by technologic advances in medicine, coupled with social and economic and legislative changes in our country today. But we must keep our eye on the ball: total patient care.

Only a few moments ago, in man-told-time, the railroads of this country were the prime source of transportation. Passenger service was meeting the demands of the public, and freight service the demands of commerce. But at the peak of this activity, railroads were interested only in railroading. Their real target, however, was transportation which they failed to consider. Unfortunately, their present target is still only railroading, which is beset with fierce competition and controls. As physicians, our "real target" is total patient care. Let us not make a similar mistake.

James A. Rogers, M.D.



# Histopathology of Granulomatous Diseases of the Chest\*

**Edward Wagman, M.D./Paramus**

The term "granulomatous" refers to a chronic proliferative reaction of the reticulo-endothelial system<sup>1</sup> which is inflammatory or neoplastic. It is characterized by lymphocytes, plasma cells, giant cells, fibroblasts, and histiocytes (epithelioid cells). The latter are probably derived in part from circulating monocytes. There is evidence<sup>2</sup> that granulomatous inflammation requires an intact immunologic mechanism but can occur without it.

Granulomatous diseases of the chest are found in association with infection, foreign bodies, hypersensitivity (allergy), and neoplasm. The cause in some, is unknown.<sup>3</sup> The tissue reactions resulting from different agents may be identical. One microorganism can cause markedly dissimilar responses. Emphasis will be placed on methods to identify these agents, when possible, so that definitive diagnosis can be made. More recent concepts including fluorescent and electron microscopy are briefly discussed below.

The types of histopathologic patterns (as determined by light microscopy) occurring in granulomatous diseases of the chest are: (1) epithelioid (tuberculoid) non-caseating, (2) epithelioid, (tuberculoid) caseating, (3) polymorphous, fibrosing, inflammatory, suppurative, (4) true foreign body, (5) angiitis (necrotizing vasculitis with collagen disease), and (6) polymorphous, neoplastic. (see Table).

## *1. Epithelioid (tuberculoid) non-caseating—*

The same "tuberculoid" reaction is caused by a wide variety of bacteria, fungi, parasites; and foreign materials such as beryllium and silicates (talc). Sarcoidosis, the etiology of which is unknown, is morphologically of this type. These granulomata are discreet or confluent, relatively circumscribed aggregates of epithelioid cells, Langhan's or foreign-body giant cells surrounded by a poorly differentiated cuff of lymphocytes and fibroblasts. Central necrosis is absent or minimal. They vary from about 0.1 of a millimeter to several centimeters in size. The epithelioid cell is a large plump histiocyte with pink granular cytoplasm which resembles an epithelial cell.

Inclusions are common in epithelioid granulomatosis. They are found most frequently in sarcoidosis. The Schaumann type consists chiefly of a conchoidal body made up of aggregates of small proteinaceous calcific spheres up to 120  $\mu$ . in diameter.<sup>3, 4</sup> In many instances, they originate as calcium and iron impregnated elastic fibers. The crystalline nidus is calcite (calcium carbonate) forming birefringent spicules and plates varying from 1 to 5  $\mu$ . Asteroid bodies are stellate structures found in epithelioid and giant cells. The central core is thought to be phospholipid in nature. They measure from 5 to 20  $\mu$ . in diameter. Centrospheres are ill-defined clusters of vacuoles within the giant cells. Birefringent crystals of cholesterol and non-

\*Read before the Sections on Chest Diseases and Clinical Pathology, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 8, 1972. Dr. Wagman is Director of Laboratories at Bergen Pines County Hospital, Paramus, New Jersey.

**Table**  
*Granulomatous Diseases of the Chest*

1. Epithelioid Type

\*A. Infection:

Bacterial—Tuberculosis, Typical and Atypical, Tularemia, Syphilis, Glanders, Melioidosis, Leprosy (Lepromatous)

Fungal—Histoplasmosis, Coccidioidomycosis, North American Blastomycosis, South American Blastomycosis, Cryptococcosis (Torulosis, European Blastomycosis) Moniliasis, Aspergillosis, Adiaspiromycosis (*Emmonsia Crescens*)

Parasites—Schistosomiasis

B. Etiology Unknown—Sarcoidosis, Nodular Granulomas Associated with Retroperitoneal Fibrosis (Benfield, 1962)

C. Inhalation of Dusts:

Mineral—Silica (Koalin), Talc (Silicates), Beryllium

Vegetable—Farmer's Lung (*Thermophillicae* Polyspora, *Micromonospora Vulgaris*, *Coniosporum* Sp.), Capsicum Lung, Maple-Bark Stripper's Lung (*C. Corticale*)

Animal—Pigeon Breeder and Budgerigar-Fancier's Lung

2. Polymorphous, Inflammatory, Fibrosing, Suppurative (Pulmonary Mycetoma)

Actinomycosis, Nocardiosis, Botryomycosis (Bacterial Pseudomycosis, Discomycosis), Allescheriasis

3. Angiitis (Necrotizing Vasculitis with Collagen Disease)

Wegener's Granulomatosis, Classic (Godman and Churg, 1954)

Lymphomatoid, and Limited (Liebow and Carrington, 1966)

Allergic Angiitis and Granulomatosis (Churg and Strauss, 1951)

Periarteritis Nodosa and Pulmonary Hypertension

Loeffler's Pneumonia

Rheumatoid Lung Disease (Necrobiotic [Gruenewald, 1948], and Kaplan's Nodules, [1953])

4. True Foreign Body Type

A. Lipids:

Cod Liver Oil, Milk, Liquid Paraffin (Mineral Oil, Nasal Drops), Poppy Seed Oil (Lipiodol), Dionsil (Aqueous and Oily Propyl iodine)

B. Mineral Dusts:

Pulmonary Angiothrombotic (Talc) Granulomatosis (Blue Velvet Disease) (Krainer, 1962; Wendt, 1964; Hahn, 1969; Taylor and Hopkins, 1970)

C. Vegetable Dusts:

Bagassosis (Sugar Cane Residue)

D. Parasites:

Pulmonary Filariasis (Tropical Eosinophilic Lung, Weingarten's Disease), Toxocariasis, Distosomiasis (Paragonimiasis)

5. Polymorphous, Neoplastic

A. Hodgkin's Disease

Paragranuloma, Granuloma, Nodular Sclerosing, Sarcoma, Nodular Sclerosing Variant of Thymus (Granulomatous Thymoma, Lattes and Katz, 1969)

B. Histiocytic Reticulosis

Eosinophilic Granuloma, Hand-Schuller-Christian, Histiocytosis X (Letterer-Siwe Disease)

C. Mycosis Fungoides

D. Plasma Cell Granuloma (Spyker and Kay, 1956)

Histiocytoma (Bates and Hull, 1958), Post Inflammatory Tumor (Umiker and Iverson, 1954), Plasmacytoma (Gordon and Walker, 1944), Vascular Endothelioma (Edwards and Taylor, 1954)

E. Sclerosing Granuloma (Liebow and Hubbell, 1956)

(Fibroxanthoma, Sclerosing Angioma, Vascular Endothelioma)

\*Those granulomata associated with infections can result in non-caseating and caseating lesions.

dissolvable substances are also present. Residual bodies are remnants of lysozymes.

Hamazaki-Wesenberg bodies are small round to spindle-shaped structures which are non-birefringent, measuring 3 to 15 micra. in diameter and found in lymph nodes. They are golden brown with hematoxylin and eosin, stain variably with periodic acid Schiff reaction, very sharply with Geimsa, and are acid-fast positive.<sup>5</sup>

2. *Epithelioid (tuberculoid) with caseation necrosis*—The central portion of the lesion is converted into a granular eosinophilic mass of amorphous fat and protein with complete loss of cell detail grossly resembling soft cheese.<sup>6</sup> They can measure a few millimeters or involve entire segments or lobes. The surrounding fibroblasts may show a radial distribution. The giant cells are multinucleated and vary from 60 to 100 mu. in size. They are probably formed by fusion of the epithelioid cells. The Langhan's type has numerous peripherally oriented small nuclei. The foreign body variety has nuclei scattered throughout the abundant cytoplasm. Phagocytized organisms or foreign material are frequently visible. Intermediate forms occur. Extensive caseation is found in tuberculosis, tularemia, the systemic mycoses, and Wegener's granulomatosis. Large areas of pulmonary parenchyma are destroyed, and fibrosis or cavitation can result.

3. *Polymorphous, inflammatory, non-specific, fibrosing, suppurative*—The polymorphous infiltrate contains plasma cells, lymphocytes, monocytes, and fibroblasts in the absence of any specific organoid pattern. There is frequently dense fibrosis. Abscess formation in which there are masses of neutrophils is usually a prominent feature. Suppuration may not be obvious. Actinomycosis, nocardiosis and botryomycosis are the leading examples of the polymorphous forms. "Granules" consisting of an intertwining mycelial-like mass of gram positive organisms are present, surrounded by polymorphonuclear leucocytes. The peripheral "clubs" representing mycelia coated with

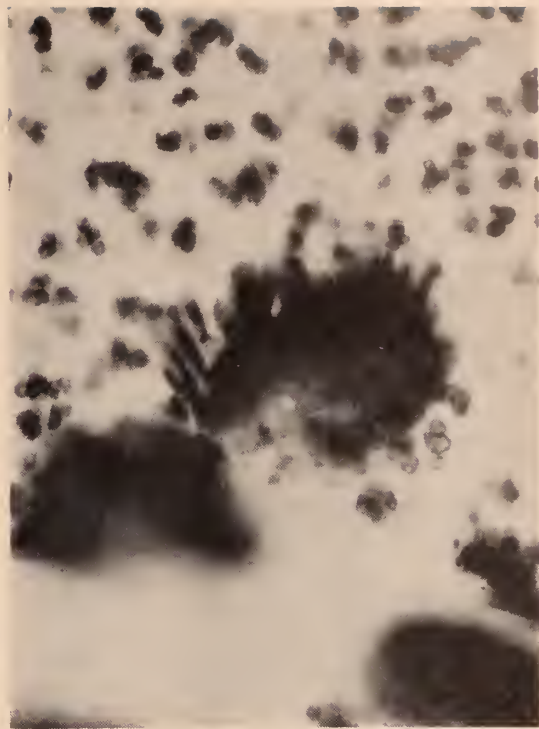


Figure 1—Actinomycotic granule with clubs surrounded by neutrophils x 1000 Gram stain.

protein are most characteristic with actinomycosis infection. (see Figure 1)

4. *The true foreign body type*—This is caused by inhalation or aspiration of various particulate matter and circulating parasites. Foreign body giant cells and histiocytes are characteristic and predominate. Aspiration of lipids such as cod liver oil, paraffin oil, and mineral oil into the alveoli and bronchiole result in an outpouring of macrophages with phagocytosis of the lipids. When these cells coalesce, multi-nucleated foreign body giant cells are formed. If the inflammatory reaction is marked, lipid material surrounded by histiocytes and giant cells can be visualized. The "foreign body" epithelioid reaction is described in group one above.

Hopkins and Taylor<sup>7</sup> and others have described intravascular and perivascular granulomata measuring from 100 mu. to 500 mu. in size, composed of histiocytes and foreign body giant cells which may contain birefringent crystals (talc). The vasculitis results in throm-



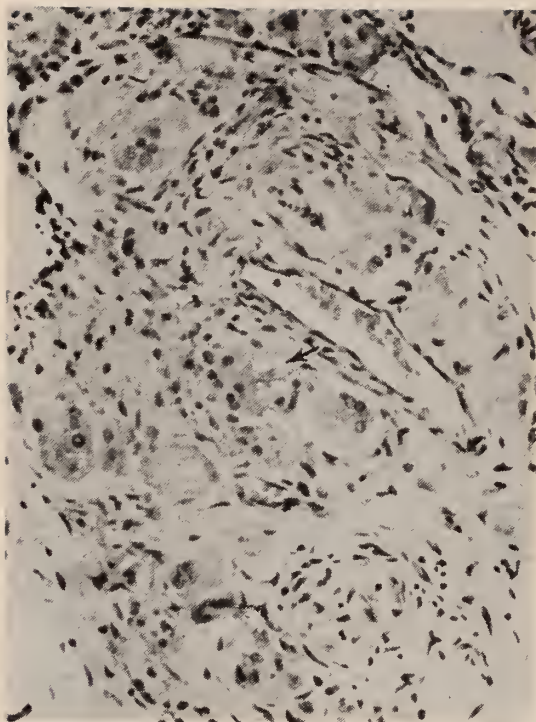


Figure 2—Intravascular granuloma composed of histiocytes and giant cells containing refractile talc particles. The vessel lumen unoccluded by the granuloma H&E x 290.

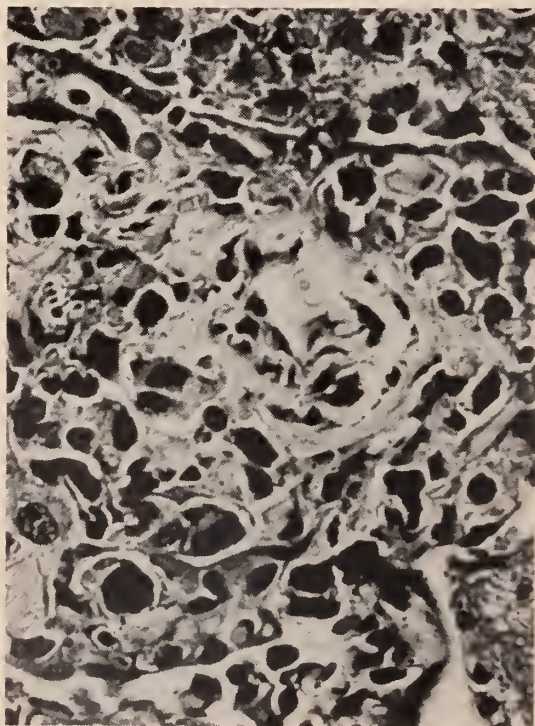


Figure 3—Atypical malignant-appearing reticular cells in Wegener's granulomatosis x 1000.

basis of pulmonary arteries, arterioles, and capillaries. Pulmonary hypertension can occur if the vascular injury is extensive. This vascular foreign body reaction is found principally in drug addicts using parenteral methylphenidate, Demerol,<sup>®</sup> or "blue velvet" (paregoric and pyrabenzamine), all of which contain hydrous magnesium silicate as a filler. (see Figure 2)

5. *Angiitis* (necrotizing vasculitis in association with collagen disease, pathergic granulomas—Fienberg, 1953)—Concomitant fibrinoid degeneration frequently occurs.

The lesion of classic or limited Wegener's granulomatosis is an extensive necrotizing vasculitis involving all small pulmonary blood vessels from less than 1 to 4 mm. in diameter. The vessel wall may show edema, swelling, fragmentation, or fibrinoid necrosis. The perivascular infiltrate is frequently prominent and includes neutrophils, lymphocytes, histiocytes, and plasma cells. Characteristic are large areas of caseous or coagulation necrosis in association with thrombosed blood vessels. At the periphery, large numbers of neutrophils are present which may be viable or degenerated. Also present are small numbers of Langhan's or foreign body giant cells with other chronic inflammatory cells. Eosinophils are rare. Angiitis occurring at the periphery or away from the necrotizing granuloma is the most outstanding differential histologic characteristic.<sup>8</sup> The limited form of Wegener's granulomatosis described by Liebow and Carrington has generally similar, but less extensive lesions. Some sarcoid granulomas are present within the parenchyma, intralobular septum, and blood vessel wall. Plasma cells are always conspicuous. Fibrinoid changes are generally not seen. Large reticulum, plasmacytoid, and Reed-Sternberg-like cells simulating malignancy have been described. They are irregular, have neutrophilic or basophilic cytoplasm, are frequently multilobulated nuclei with prominent nucleoli. Some cells are smaller, spindle-shaped with scanty cytoplasm and have hyperchromatic nuclei. These are believed to represent altered reticulo-endothelial cells. (see Figure 3)

Allergic angitis and granulomatosis are similar to Wegener's disease. The lesions are less severe. Eosinophilic infiltrates are characteristic. There are minute nodules with a central necrotic zone of fibrinoid or infarcted parenchyma surrounded by radially distributed fibroblasts and small foreign body giant cells. Eosinophils and lymphocytes are present in the alveolar and bronchiolar walls. These are accompanied by periarterial, pericapillary inflammation or acute granulomatous periarteritis nodosa.

In Löffler's pneumonia the alveoli are filled with eosinophils, histiocytes, and giant cells. Necrotic changes are minimal or absent. The process may involve the bronchiolar walls and the alveolar septa. Focal fibrinoid capillaritis is observed in the more severe forms.

The lungs are not frequently involved in polyarteritis nodosa. There is a tendency for the arterial lesions to be accompanied by a reparative granulomatous reaction.<sup>9</sup> A segment of the affected vessel is infiltrated and replaced by histiocytes and other mononuclear cells which blend with the surrounding perivascular inflammation. Eosinophils are numerous. In acute polyarteritis associated with pulmonary hypertension the lesions are confined to the muscular arteries in which there is fibrinoid necrosis and an inflammatory cell reaction which are usually confined to the intima and only involve the media in the smallest branches. There is little perivascular reaction in contrast to periarteritis nodosa. In subacute cases there is segmental scarring of the arterial wall and partial or complete destruction of the elastic laminae.

Rheumatoid lung disease is usually characterized by pleurisy and interstitial pneumonitis, which can result in destruction of alveoli, bronchiolar, and blood vessel walls. Rarely, necrobiotic nodules, similar to those in the subcutaneous tissue occur. They measure from 0.5 to 2 cm. in largest dimension, and are present within the pleura or parenchyma and have central areas of fibrinoid necrosis. The area of degeneration is surrounded by palisaded fibroblasts and histiocytes.<sup>9</sup> They may cavi-

tate and cause pneumothorax. Kaplan's nodule is a similar lesion which contains a large quantity of anthracotic pigment and is found in coal miners and foundry workers. At the periphery there is often a cleft surrounded with neutrophils.

6. *Polymorphous, neoplastic*—These lesions are categorized by granulomatous infiltrates, in which there are usually large atypical sometimes multinucleated reticulum cells, and plasma cells.

(a) *Hodgkin's disease*—Primary Hodgkin's disease occurring in the lung is rare. Forty percent of all cases probably affect the mediastinum and/or the lung. The classification of Jackson and Parker has been extended and includes: paragranuloma, granuloma, sarcoma, and nodular sclerosing types. The granulomatous and the nodular sclerosing forms are the most common. Histologically there is lymphocytic proliferation, reticulo-endothelial hyperplasia, fibrosis, eosinophilic, necrosis, and Reed-Sternberg cells. The nodular sclerosing type has highly cellular areas with the cytologic features of Hodgkin's disease which are separated by wide dense bands of fibrous tissue. The borders of these cellular areas are smooth. Granulomatous thymoma is now thought to represent an unusual variant of nodular sclerosing Hodgkin's disease in which the presenting lesion involves the thymus but not the mediastinal or peripheral lymph nodes. The granulomatous components resemble nodular sclerosing Hodgkin's disease although the Reed-Sternberg cells were often atypical, frequently containing periodic acid Schiff positive material and often appeared to arise in or from thymic epithelium. Thymic epithelium participates in the process of producing sheets of squamoid cells and/or cystic structures lined with columnar cells. A Hassall's corpuscle or some other focus of thymic epithelium is often present. The cellular areas are irregular in outline, in contrast with the classic sclerosing nodular type.<sup>10</sup>

(b) *Histiocytic reticulosis*—These disorders include eosinophilic granuloma, Handschüller-Christian disease, and Letterer's Siwe



disease (histiocytosis X). They have very similar histologic patterns which merge imperceptibly with one into the other. They consist of an admixture of histiocytes with a reniform or oval nucleus, often foamy cytoplasm containing cholesterol; eosinophils, giant cells, lymphocytes, fibroblasts, and histiocytes. The destruction of the alveolar septal and bronchiolar walls, blood vessels, with fibrosis can produce pulmonary hypertension and honeycombing. The diseases are best differentiated on clinical rather than histologic grounds.<sup>3</sup>

(c) *Mycosis fungoides*—This is a primary lymphoma of skin characterized clinically by pre-mycotic (erythematous) plaque and tumor stages. Classically there is a polymorphous infiltrate of the skin in which there are large atypical reticulum cells, in addition to histiocytes, plasma cells and lymphocytes close to the epidermis. Edgecomb and his associates have stated metastasis occur most frequently in the lungs.<sup>11</sup> It is unlikely that mycosis fungoides can be distinguished from Hodgkin's disease by morphology alone.

(d) *Plasma cell granuloma*—(Histiocytoma, vascular endothelioma post inflammatory tumor) There is difficulty in determining whether this abnormality is truly neoplastic or inflammatory in origin. It has tentatively been classified as a tumor. The cell infiltrates consist of plasma cells, perithelial cells, fibroblasts and histiocytes, many of which may be foamy or hemosiderin laden. They are distinguished from solitary plasmacytomas by their granulomatous appearance. They are benign and usually solitary.<sup>3</sup> In some cases, the plasma cells are quite pleomorphic, being elongated or spindle-shaped and may simulate fibroblasts. Those which are of some duration have abundant intracellular hyalin resembling amyloid, and in the late stages this material may overshadow all other components. Plasma cell granulomas adjacent to small bronchus superficially may appear to invade or envelop this structure by virtual infiltration of the bronchiolar wall. A mild angiitis predominantly with plasma cells is sometimes seen.<sup>8</sup>

(e) *Sclerosing granuloma* (Sclerosing angio-

ma, vascular endothelioma, fibroxanthoma)—A benign tumor occurring most often in the upper lobe, frequently in women below the age of fifty. Microscopically they originate from proliferating endothelial tissue (or alveolar mesenchymal bands) forming vascular papillary structures, the central portion of which becomes hyalinized. These structures are covered by endothelial (or epithelial) cells which eventually atrophy. Hemorrhage frequently causes the production of hemosiderin and lipid laden macrophages. Finally the tumor consists chiefly of a sheet of hyalinized connective tissue.<sup>3</sup>

### Differential Diagnostic Methods

(a) *Special stains*—Multiple or serial sections are examined. The Brown and Brenn (Gram) stains, clearly define the mycelial mass characteristics of the actinomycotic granule which is easily seen with a low power objective. The Kinyoun (acid-fast) stain is effective in tissue in outlining mycobacterial rods. These organisms are probably best seen within exudate or in necrotic debris. Acid-fast organisms however, do not necessarily indicate mycobacterium tuberculosis since *M. Kansaii* and *M. Intracellulare* (Battey) can be found in tuberculous-like diseases of the lung. A mucicarmine stain delineates the delicate wall of cryptococcus neoformans to advantage and an india-ink preparation shows its wide capsule. The Grocott (silver methenamine) procedure is required to demonstrate the small (1 to 5  $\mu$ .) yeast-like intracellular or extracellular structures of histoplasma capsulatum. The periodic acid Schiff reaction reveals the double contoured wall of blastomyces dermatitidis and the spherule and endospores of coccidioides immitis. The granule of allescheria boydii is larger than actinomycosis and has spores in association with the hypha at its margin. The dichotomus branching of aspergilli, the septate hyphae and spores of candida, and the broad non-septate hyphae of mucor usually near blood vessels are fairly characteristic.

Mineral oil is yellow to orange with Sudan Four but does not stain with osmic acid. Cod



liver oil is redder with Sudan Four and black with osmic acid. Paraffin oil is salmon pink in color. Silver nitrate is used to detect lipiodol in frozen tissue sections which have been fixed in formalin.<sup>6</sup> A Verhoeff stain is helpful in outlining blood vessels in cases of necrotizing angiitis. Schistosoma are generally identifiable by the hemotoxylin and eosin method.

(b) *Polarization light microscopy*—Birefringent crystals greater than 0.5  $\mu$ m. can be visualized in sarcoidosis, talcosis and other diseases. Examination with diminished light frequently will demonstrate non-birefringent materials, such as parasitic cysts.

(c) *Fluorescent microscopy*—Mycobacterium tuberculosis may be found in paraffin embedded autopsy and biopsy tissues stained with auramine and rhodamine which are negative by the carbol fuchsin method.<sup>12</sup> Gamma globulin and fibrinoid have been demonstrated in collagen disorders.<sup>1</sup>

(d) *Culture*—Culture of surgical pathologic specimens for micro-organisms is an essential part of the examination and should be carried out routinely. Sometimes no organisms are seen in tissue sections. Their morphologic characteristics may be similar (actinomyces and nocardia, aspergilla and monilia, blastomyces and coccidioides). Non-viable organisms of older noninfective lesions may be identified in tissue and not grown on culture media. Surgical or autopsy specimens should be submitted in the unfixed state. Fungi can survive in 10 per cent formalin for one to two hours depending on the thickness of the tissue.

(e) *Electron microscopy*—The ultrastructure of the epithelioid cell consists of numerous mitochondria, rough endoplasmic reticulum, golgi bodies and cytoplasmic vesicles, and dense lysozymes.<sup>12,13,14,18</sup>

Greenberg, *et al.*,<sup>13</sup> noted cytoplasmic inclusions in lungs of five patients with sarcoid. They varied from 0.2 to 0.4  $\mu$ m in size and had an oval or elongated dense core and a

narrow electron—lucent peripheral rim surrounded by an electron dense membrane. These inclusions did not stain with Ziehl-Neelsen periodic acid Schiff, Oil Red O, or by the fluorescent technic. The authors postulated that they might represent atypical forms or mutants of tubercle bacilli. (see Figure 4)

Williams, *et al.*,<sup>11</sup> have differentiated two types of epithelioid cells. The "A" type is distinguished by the predominance of lamellar rough endoplasmic reticulum and is found chiefly in tuberculosis. The "B" variety has more numerous golgi complexes and vesicles; and is considered characteristic of sarcoidosis.

Tubular particles with transverse striations and sometimes terminal dilatations have been described in the cytoplasm of histiocytes and fibroblasts in patients with Letterer-Siwe disease. (see Figure 5) They vary from 400 to 450 Angstrom units in size. They could be of viral origin or represent stored organic mate-

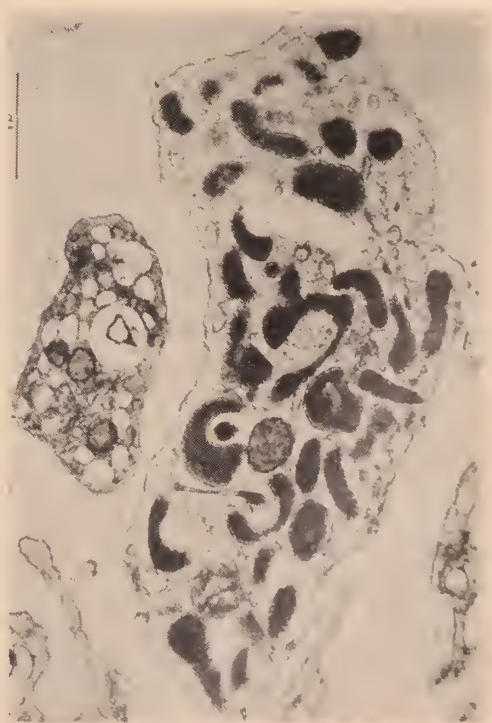


Figure 4—Electron photomicrograph demonstrating the unique cytoplasmic inclusions within an epithelioid cell. Note the oval, electron-dense core of the inclusions with a narrow electron-lucent rim surrounded tightly by an electron-dense membrane. Luranyl acetate and lead citrate stain  $\times 31,000$ .

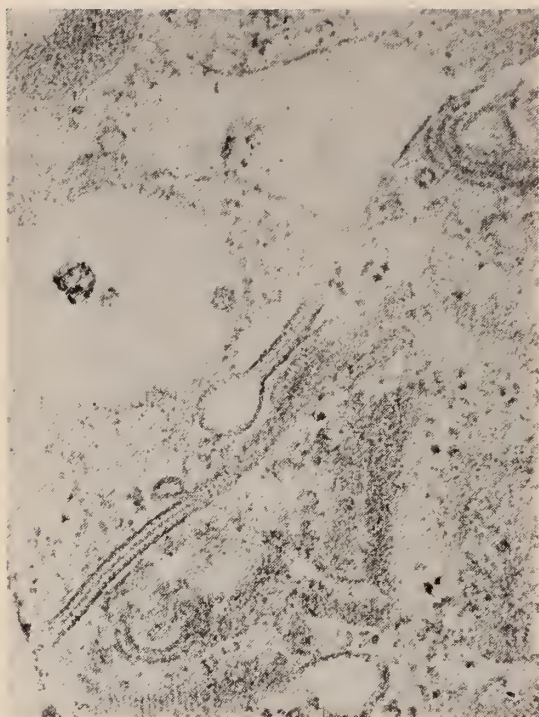


Figure 5—Tubular particle with transverse striations and terminal dilatation in the cytoplasm of histiocyte x 27,000.

rial.<sup>15</sup> The electron microscope and x-ray diffraction crystallography have established the presence of an identified talc and other mineral dusts in tissue.<sup>16</sup>

## Discussion

Infectious diseases can be distinguished successfully in most cases by judicious examination of sufficient tissue sections (H.&E.), use of special stains, and culture for microorganisms.

The diagnosis of sarcoidosis depends on close clinical pathologic correlation, the presence of a non-caseating epithelioid granulomata frequently with schaumann (80 per cent) and asteroid bodies (60 per cent), a positive Kveim test, and usually no demonstrable causation agent. Significant serologic reactivity has been found against atypical mycobacterium. Rarely these have been noted<sup>17</sup> in tissue sections in patients with clinical sarcoidosis. Hamazaki-Wesenberg bodies occur in about 20 to 30 per cent of the cases in the United States and about 67 per cent of pa-

tients in Europe. Baro and Butt<sup>5</sup> believe they may be the lysogenic mutants of tubercle bacilli described by Mankiewicz. The Hamazaki-Wesenberg bodies were present only in patients with mild or self-limited disease. Elias and Epstein<sup>18</sup> suggest that organization of epithelioid cells into tubercles is a specific event characteristic of granulomatous hypersensitivity.

Foreign body granulomas are differentiated by light and polarization microscopy, electron microscopy, and x-ray defraction (crystallography).

Necrotizing vasculitis frequently with fibrinoid changes is the key diagnostic factor in the "angiitis group." Each disease is distinguished by its clinical presentation and the distribution and extent of the anatomic lesions.

The histologic similarity of Wegener's granulomatosis with neoplastic disorders such as Hodgkin's disease, reticulum cell sarcoma or other forms of lymphoma have been previously noted above. The extensive necrotizing angiitis again provides the best clue to the correct interpretation. The differentiation of the neo-plastic disorders requires correlating clinical data and histopathology.

## Summary

The granulomatous diseases of the chest have been classified on the basis of histopathologic pattern. Many are very similar morphologically. Light microscopy, with its various applications, remains the basic diagnostic tool in their differentiation. Clinical pathologic evaluation, culture of tissue specimens and biologic fluids, and skin serologic tests are necessary adjuncts. Electron microscopy and x-ray diffraction should be carried out in selected cases if the diagnosis is not apparent.

Thanks are expressed to Cesar Baro, M.D., J. K. Chorney, M.D., Jacob Churg, M.D., S. Donald Greenberg, M.D., G. Bruce Hopkins, M.D., Martin Lefkowitz, M.D., Rafael Lattes, M.D., J. Turiaf, M.D., H. Spencer, M.D., Irving Weiss, M.D., Richard Mendez, and Mrs. Rita Henry.



## Bibliography

1. Boyd W.: *Textbook of Pathology: Structure and Function in Disease*, Ed. 8, pp. 94, 95, 111-113. Philadelphia, Lea & Febiger, 1970.
2. La Via, M. G. and Hill, R. B.: *Principles of Pathophysiology*. New York and London, Oxford University Press, 1971.
3. Spencer, H.: *Pathology of the Lung*, Ed. 2. London, Pergamon Press, 1968.
4. Williams, W. J.: Proceedings of the Royal Society of Medicine, Vol. 60 (October 1967)
5. Baro, C. and Butt, C. G.: *Laboratory Medicine—The Bulletin of Pathology*, 281 (September 1969)
6. Robbins, S. L.: *Pathology*, Ed. 3, p. 53. Philadelphia, Saunders, 1967.
7. Hopkins, B. and Taylor, D. A.: *American Review of Respiratory Disease*, 101:101 (February 1970)
8. Carrington, C. B. and Liebow, A. A.: *American Journal of Medicine*, 41:497 (October 1966)
9. Gardner, D.: *Pathology of the Collagen Disorders*, pp. 96-99, 194, 209. Baltimore, William and Wilkins, 1965.
10. Katz, A. and Lattes, R.: *Cancer*, 23:1 (January 1969)
11. Clinicopathologic Conference: *American Journal of Medicine*, 42:129 (January 1967)
12. Wilner, G., Solange, A. N., Siket, A., and Azar, H. A.: *The American Journal of Clinical Pathology*, 52:584 (1969)
13. Greenberg S. D., Gyorkey, F., Weg, J. G., Jenkins, D. E., and Gyorkey, P.: *American Review of Respiratory Disease*, 102:648 (October 1970)
14. Williams, W. J., Erasmus, D. A., James-Valerie, E. M., and Davies, T.: *Journal of Medical Microbiology*, 3:6 (February 1970)
15. Gracey, D. R., Divertie, M. B., and Brown, A. L., Jr.: *Chest*, 59:5 (January 1971)
16. Miller, A., Tierstein, A. S., Bader, M. E., Bader, R. A., and Selikoff, I. J.: *The American Journal of Medicine*, 50:395 (March 1971)
17. Chapman, J. S. and Speight, Maro: *Acta Medica Scandinavica Supplement*, 425:61 (1964)
18. Elias, P. M. and Epstein, W. L.: *American Journal of Pathology*, 52:1207 (1968)

Bergen Pines County Hospital

## Alternatives to Drug Taking

The National Institute of Mental Health is exploring a new approach in the fight against drug abuse—emotional substitutes to drug addiction. The project, called "Alternative Pursuits for America's Third Century," will seek those substitutes by encouraging communities to devise innovative programs and activities to turn people away from drugs by fulfilling some of the needs that drive them to drugs.

The NIMH, a component of HEW's Health Services and Mental Health Administration, is the lead agency in the federal program against drug abuse. It sponsors drug abuse information and education programs and supports research, training, and treatment services. "Drug abuse basically springs from boredom, alienation, and a sense of inability to cope with life," says Dr. Bertram S. Brown, NIMH Director. "Efforts to combat drug abuse are futile unless we expand opportunities for young people and adults to find satisfaction and meaning in today's world."

NIMH plans to stimulate ideas and designs for these activities in the next three months, and organize a national collaboration to give communities experience in determining alternatives. A conference will be held in June at Warner Hot Springs, California. Already set up is a network of more than 1,000 young people and adults in communities across the country who will form teams to invent alternatives, or improve existing ones. The need is for anyone in the community with ideas, knowledge of how to make things work in their local area, and persistence and energy.

As teams are organized, they will receive assistance by mail, using extensive descriptive and how-to materials, exercises, games, and tape cassettes.

Information about participation in this project can be obtained from Alternative Pursuits, P.O. Box 861, Del Mar, California 92014.



*A language barrier may throw a wall of isolation around anyone, a particularly unhappy development if the patient is mentally unstable anyway.*

# Ethnic Isolation and the Bilingual Patient

---

**Julio C. Del Castillo, M.D./Trenton**

Isolation as part of a medical program has been used for centuries. The process of isolating a patient who suffers from a communicable disease, thus separating him from contacts with others, is, of course, quite frequent. Quarantine is a type of isolation applied to vessels or persons suspected of carrying contagious disease. This is of prime importance for public health. Isolation in preventive medicine is also important. In non-communicable diseases, isolation is used more frequently than might be thought; the recovery rooms, the quiet rooms, the intensive care unit, and so on, are specific forms of isolation. In a way, so is any kind of hospitalization. The prescription of bed rest, restriction of activities, and the like, constitute milder forms of isolation.

In psychiatry, isolation as a regulated system for promoting mental health has been used for centuries. According to Janet<sup>1</sup>, "The chief difficulties in life arise in connection with social relationships, and social activities are more exhausting than any other kind. On this recognition has been based a method of treatment which is often associated with the rest cure of nervous diseases, namely, treatment by isolation."

The modern psychiatrist will often prescribe isolation. This could range from milder forms such as advising a patient to "get away on a vacation," "keep away from business for a while," and so on, to actual confinement in a psychiatric installation.

Confinement in a mental hospital is generally one of two types: commitment or voluntary. Commitment is available when the patient is considered to be a danger to himself or to others or to property.

The concept of social isolation as such is not new. However, ethnic isolation along language lines has, to the best of my knowledge, not been systematically explored to date and the present article may help to open new avenues in this direction. The ultimate goal of such controlled ethnic environment would be a condition in which the therapy could be discontinued. The connections between language and mental health are numerous but often not obvious.

A Cuban refugee is employed as a bus driver in a New Jersey town. He is a jovial, alert, intelligent family man with a wife and small children to support. He came to this country only a few months ago, escaping from his native land. He likes his job, and is proud of the fact that he passed his driving license examination which he was allowed to take in Spanish. He has learned a few traffic signs in English. Otherwise his knowledge of this language is limited. The bus driver is thankful for the opportunities he is given in this country.

While he was driving along a local thoroughfare, an elderly lady passenger asked him to stop the bus. He kept driving and finally stopped a few blocks further. In stepping out,

<sup>1</sup> Janet, P., *Psychological Healing* (translated by E. and C. Paul) New York, Macmillan, 1925.

the old woman said repeatedly, "son of a bitch." Smiling, he replied in unmistakable broken English, "Thank you." At the end of the work day, he visited his niece, told her about his apparent mistake of not stopping for the old lady on time and inquired about the meaning of her parting remark. Laughing out loud, she explained it to him and both laughed. He asked what to do if a similar circumstance happened in the future. In accordance with her instructions, from that time on, he would say, "Same to you," when addressed in English. He then may laugh, even though it is possible that he is being ridiculed, offended, or belittled. English words do not seem to have an emotional impact on him.

Apparently, offensive taunts and ridicule can be tolerated by the foreigner as he fails to realize the full weight of their connotation. In his native tongue, however, he will react accordingly. This is what Sullivan<sup>2</sup> probably refers to when writing of anxiety about an impending threat to the personality in the context of one's social environment. This describes a state of tension when we fear an unfavorable comment by someone of consequence. In such a setting, difficulties in communication will aggravate the situation. Here are several case histories to illustrate the concept researched by the author of this study.

### Case One

In the fall of 1969, I interviewed in my Trenton office a male of Latin-American origin, aged 52. He had been referred for psychiatric evaluation and recommendations by the Rehabilitation Commission. This was our first interview. I found him to be friendly, cooperative, able to relate well, and he mentioned that he was feeling comfortable in his home family care placement, where he had been living for about two months since his release from the State Hospital. The home was located in a ghetto area. He described his sponsor, a lady, as "very nice," asserted that three other patients in the home are "very good"

and indicated that "my problems are with the Puerto Ricans and the Cubans."

His background history reveals that in his native Cuba he had been living at a social level much higher than where he was forced to live when he came to the United States seven years ago. Back home, he was a successful businessman, owner of a grocery store. During his residency in the USA, he had experienced difficulty with all Spanish-speaking people. He was obsessed with the idea that unpleasant references were constantly made to him by them, and he was primarily disturbed by their characterization of him as a *Maricon*—a homosexual.

Since his residence in this country, he had held a variety of jobs as porter, maintenance worker, and janitor—repeatedly experiencing difficulties with his compatriots, constantly thinking that they were calling him *Maricon*. He even pulled a knife on his "enemies" on different occasions. He moved from New York to New Jersey and from there to Pennsylvania, kept fighting his "enemies," failed to adjust, and required repeated hospitalization in psychiatric wards for several weeks or months. But he was always discharged to his family until his hospitalization at Trenton State Hospital when it was decided to place him on Family Care Program.

Handicapped by a language barrier, the patient seemed anxious to acquire a knowledge of English in a somewhat unrealistic desire of establishing his own business. He was eager for employment. My recommendations to the Rehabilitation Commission were as follows:

1. The study of English should be pursued at adult evening classes.
2. Employment would be preferable in an environment free from Spanish-speaking individuals.
3. Major tranquilizing medication should be administered.
4. Psychotherapy twice monthly for an indeterminate time.

I kept seeing the patient on a regular basis as agreed. His learning of the English language proceeded slowly due to his age and the emo-

<sup>2</sup> Sullivan, Harry S., *The Interpersonal Theory of Psychiatry*, New York, Norton, 1953, p. 113

tional overlay. He was reluctant to identify with or establish meaningful relationships and association with people of his own ethnic background. He remained essentially comfortable and suitably adjusted at his placement under the home family care program; and his family (wife and grown children) managed to convince the patient to come home for a brief visit in an essentially Spanish environment in a town in northern New Jersey for the 1969 Christmas holidays. He found the contact with Spanish-speaking people emotionally disturbing, and returned to Trenton in an agitation so intense that I had to see him on an emergency basis.

A couple of months later he still complained that he could not go to North Jersey because of "what they had been saying and still were repeating," and he asserted that the rumor about him being *Maricon* had been widely spread among the entire Spanish community even on Perry Street in Trenton (site of the Puerto Rican community), a place that he actually doesn't frequent.

In discussing personal relationships, he indicated that he considered me the only exception since while at my office, he sees only Americans among my patients and my colleagues, and I was the only Spanish-speaking person he trusted.

Later he secured a job as a laborer in a factory where he was the only Spanish-American. He became self-supporting and kept living in the ghetto. One day, en route to the evening school for English classes, he was beaten up by a gang of black citizens with the intent of robbing him. He managed to defend himself, fighting back, and running to a safe place. On that occasion he was badly bruised and while in my office recapitulating those events, he said that he understood that the Negroes are poor, discriminated against, and that many are forced to a life of delinquency, and this wouldn't have happened if they were given better opportunities. A few months later he was attacked again by another group of Negroes. At that time he had already been

laid off from work. His folks convinced him to move back to his family in North Jersey and he secured a job as a maintenance man in a building in Manhattan—working at night, returning home early in the morning. While at his home, he remained in his room most of the time and went out to the streets at night to get the bus to work, constantly expressing his feeling that although he hadn't been called *Maricon* as yet in these surroundings, he was sure it would happen sooner or later, asserting that while walking the streets he has a feeling of panic and he feels great relief while riding the bus. He reported that at his job there were hundreds of Cubans, Puerto Ricans, and other Spanish-speaking people, employees in charge of the maintenance of the huge building; and while they had not been poking fun at him, indubitably they soon would do so.

He complained that at his home he was treated like a stranger; he was not the head of the family anymore, being rejected by his wife and belittled by all the members of his immediate household.

Arguments at home became daily events. He became increasingly suspicious, shaky, and tense, complaining of a feeling of impending physical harm and of threats to his person as "a rumor of tremendous proportions had been spread among the Cubans and other Spanish-speaking people that I am a *Maricon*." He said that they were talking about him among themselves. He expressed the relief he felt when riding in a subway, or going to places where he didn't see Spanish-speaking people and stressed the recurrent feeling of fear when near them.

After seven months' residence in North Jersey, the patient returned on a voluntary basis for his readmission to the State Hospital. At present he is still at the hospital. He enjoys ground privileges, is engaged in multiple activities—being helpful to hospital employees, doing the cleaning of his ward, and the like. He maintains a distance from other Spanish-speaking patients, but feels very comfortable



in his present environment and is most polite, courteous, and cooperative.

This individual had given evidence of being potentially dangerous to himself and to others—particularly in a Spanish environment, while being apparently innocuous, very pleasant, and agreeable in an English-speaking setting.

Here is another case highlighted by way of comparison:

### Case Two

This is a Puerto Rican in his early fifties, charged with murder. He has a long history of mental illness. He is now a patient at the Forensic Unit of the Trenton Psychiatric Hospital. He is severely psychotic and had been in and out of the segregation ward, being unable to adjust to the population of his unit for any considerable length of time. He fights and attacks others without provocation. He suffers from multiple delusions, such as being called *Maricon*, and he claims that there is a conspiracy of Puerto Ricans to rape him and abuse him sexually. Because of his delusions and his aggressive, unpredictable behavior, the special order was given to keep any Spanish-speaking patient away from him. On many occasions while I made rounds with some colleagues, he released a barrage of profanity toward me and were it not that he was behind bars he surely would have attacked me. He accused me of being part of the Puerto Rican conspiracy and to my statement that I am not Puerto Rican, he angrily claimed, "You are all the same," referring to the fact that I *am* of Spanish background. One Friday, while making rounds in company of another Spanish-speaking doctor, an American psychiatrist, and a group of attendants (including one Puerto Rican), the patient became agitated, demonstrating assaultive behavior and using very foul language, and released a stream of profanities at us. At this time, the American psychiatrist approached the patient who was courteous and polite toward him. The patient apologized for his behavior, telling the physician that he had

nothing against him because he was a gentleman and told him that we were just a "bunch of sex perverts."

### Case Three

A bilingual Puerto Rican in his late twenties was charged with armed robbery. This patient is in the maximum security building of the Trenton Psychiatric Hospital. Throughout his hospitalization he had been suffering from auditory hallucinations, hearing a male voice calling him *Maricon* (a homosexual) and *cornudo* (cuckold). He reacts to the voices, turning back to fight his imaginary aggressor. Generally, he finds nobody or a group of American patients or attendants and comes to the conclusion that the voice must be his imagination, reasoning that "how in the world could these Americans call me such names if they don't speak Spanish?" In spite of being bilingual, the patient consistently claims that he never hears a "voice" talking to him in English.

### Conclusion

Evidence indicates that foreign-born psychotic patients, when talking in their second language (English), might appear to be normal, giving a deceptively favorable impression, or they might seem to be coherent, rational, and factual as probably the intellectual effort of expressing oneself in a foreign language, in which one lacks fluency, may at times improve contact with reality. A foreign-born individual who thinks and dreams in his own language, will—if he becomes psychotic—distort reality in his thoughts, verbalized in his native language.

A patient under the influence of auditory hallucinations most probably hears voices in his native tongue. If he is bilingual and occasionally under the impression of hearing voices in English, this might not have sufficient impact to make the person react violently.

A patient under the influence of delusions will most likely be delusional in his own

thinking, in relation to his cultural and environmental background. Different individuals from various nationalities express different anxieties. Regarding persecutory delusions, for example, a Cuban might feel persecuted by Castro, a Dominican by Trujillo, a Jew by Hitler, and so on.

The apparent stability of a foreign psychiatric patient in an environment not his own can be attributed in a large measure to the fact that an essentially American environ-

ment eliminates the "protagonists of his tortures." Fear disappears through conquest, by fighting, or through escape. By placing the foreign-born patient away from his threatening environment, he feels he has escaped.

These observations seem to lead to a new modality of psychiatric treatment of *ethnic isolation* which would include rehabilitation for the foreign-born in a predominantly American environment, a method proposed by this researcher.

1002 Hamilton Avenue

### Passive Infants More Likely to Become Intelligent Youngsters

Contrary to what proud parents have long believed, the most responsive, vigorous newborns may *not* be the infants who develop into the most intelligent and active children. According to HEW's National Institute of Mental Health, babies who are more passive during their first few days of life are more likely to mature into intelligent, responsive youngsters.

Newborns with a slow rate of breathing, a slow, lethargic response to interruption of sucking, and a relative insensitivity to touch are likely to develop into assertive, active, highly verbal toddlers. On the other hand, infants who breathe rapidly, are highly sensitive to touch, and who quickly react to interruption of sucking often exhibit lower levels of activity and performance at 2½ years of age.

Dr. Richard Q. Bell, Chief, NIMH Child Research Branch, who headed this research, says that although vigor and responsiveness have been considered healthy signs in newborn infants, "it is possible that a state of relative

torpor could be a protective mechanism in the transition from uterine to extrauterine existence. Thus, this torpor could be a sign that the developmental processes are proceeding properly."

It is found that many of the behaviors exhibited by the children as preschoolers persisted until the children were at least 7½ years old, the oldest group studied by the NIMH scientists in this project. Scientists are not certain what accounts for these apparent correlations between certain newborn behaviors and later functioning. Several possible explanations are offered. One is that infants who are overly aroused and overly responsive in some way adversely affect their parents' behavior toward them so that an assertive, enthusiastic, sociable youngster does not emerge. Scientists—and parents—have observed that infants who are restless and irritable tend to absorb their mother's time in caretaking behavior, leaving little time for social interaction. More social interaction may be needed for the child to show activity at the preschool period.

# DYAZIDE®

Each capsule contains 50 mg. of Dyrenium®  
(brand of triamterene) and 25 mg. of hydrochlorothiazide.

Trademark

## CAN STOP POTASSIUM DEPLETION BEFORE IT STARTS

## WITH NO SACRIFICE OF THIAZIDE EFFECTIVENESS

Before prescribing, see complete prescribing information in SK&F literature or PDR.

**\*Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $> 5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis,

and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

**SK&F CO.**

Carolina, P.R. 00630

a subsidiary of Smith Kline & French Laboratories

## IN EDEMA\* — IN HYPERTENSION\*



# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.  
1st choice: Switch to a combination 50-mcg -estrogen O.C. (such as **Demulen**®).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of menorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**®).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**®).

Age 21, short, mammary, with normal menses, some acne. Was put on pre-nuptial regimen of 50-mcg -estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg -estrogen combination (such as **Enovid-E**® or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

\*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. as recurrent trichomoniasis and Monilia.

Indicates estrogen deficiency and excess of progestogen in current O.C.

1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E**® or **Ovulen**® or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.

Indicates probable need for more estrogen.

1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen**®).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.

Indicates probable progestogen excess.

1st choice: Switch to a center-spectrum pill (such as **Ovulen**®).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.

Indicates probable excess of estrogen.

1st choice: A 50-mcg.-estrogen progestogen-dominant pill (such as **Demulen**®).

**Ovulen**® a balanced center-spectrum O.C. for most

Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

**Demulen**® a moderately progestogen-dominant O.C. for many

Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients. Both Ovulen and Demulen are available in 21- and 28-pill schedules.

SEARLE

Products of SEARLE & CO.  
San Juan, Puerto Rico 00936

**Enovid-E**® a moderately estrogen-dominant O.C. for some

Each tablet contains norethynodrel 2.5 mg./mestranol 0.1 mg.

SEARLE

Product of Searle Laboratories Division  
G.D. SEARLE & CO.  
P.O. Box 5110, Chicago, Illinois 60680  
Where "The Pill" Began

For a brief summary of prescribing information, please see next page.



a family of O.C. products to help you match  
the right pill to the right patient

# Ovulen®

Each white tablet contains  
ethynodiol diacetate 1 mg/mestranol 0.1 mg.

# Demulen®

Each white tablet contains  
ethynodiol diacetate 1 mg/ethinyl estradiol 50 mcg

Each pink tablet in Ovulen-28® and Demulen-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>1</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of sub-primate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function; increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X, thyroid function; increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, *J. Coll. Gen. Pract.* 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, *Brit. Med. J.* 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, *Brit. Med. J.* 2:651-657 (June 14) 1969. 4. Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives. An Epidemiologic Case-Control Study, *Amer. J. Epidemiol.* 90:365-380 (Nov) 1969.

SEARLE

Products of SEARLE & CO.  
San Juan, Puerto Rico 00936

# Enovid-E®

norethynodrel 2.5 mg/mestranol 0.1 mg

**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions and Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

## Enovid-E®

brand of norethynodrel with mestranol

SEARLE

Product of Searle Laboratories Division  
G. D. SEARLE & CO.  
P.O. Box 5110, Chicago, Illinois 60680  
Where "The Pill" Began



*Five common anorectal conditions that can usually be handled in the office are here presented.*

# Common Anorectal Problems\*

## A Guide to Office Treatment

---

**Dave B. Swerdlow, M.D./Glen Ridge**

The anorectal area is so sensitive that pain and discomfort can be incapacitating. Actually, rapid and effective relief can be accomplished simply and with a minimum of equipment. Office treatment can afford prompt relief of symptoms, permitting the patient rapid return to normal activities.

### Thrombosed External Hemorrhoid

A thrombosed external hemorrhoid is a clot in or surrounding those varicosities or hemorrhoids covered with skin. It is located distal to the dentate line. It presents a bluish swollen tender marble-like lump. If ulcerated, it can bleed profusely. Pain may be constant, throbbing in nature, and varies considerably in intensity. Thrombosed external hemorrhoids will resolve spontaneously in about two weeks. If the patient is not in severe pain and is able to sleep, walk about, and go about his daily routine, conservative measures should be recommended. Sitz baths and a bland suppository twice daily will provide adequate relief until regression occurs. A stool softener is helpful (Surfak® 240 milligrams b.i.d.).

Pain may be excruciating. If the patient is unable to perform his usual daily tasks, surgical intervention is indicated. This may be accomplished by removing the clot with the aid of local anesthesia. No elaborate pre-operative cleansing or preparation is necessary. About 2 cc of Lidocaine® 1 per cent with adrenalin 1 to 100,000 is infiltrated locally. A skin wheal is raised at the lateral borders, using a size 28 or 30 needle. Only the

skin is infiltrated in a field block technic surrounding the clot in a diamond shape. Save the final 0.5 cc to be injected directly under the clot. Massage the locale gently for about thirty seconds. If your anesthesia is adequate, the patient will be asymptomatic at this time.

Grasp the summit of the hemorrhoid with an Allis clamp. Unroof the swollen bluish area and remove the clot. Little bleeding will obscure your field due to the local anesthesia.

1. Be sure to bring the wound out far enough or a post-operative fissure will result.
2. Do not carry the wound to or across the dentate line. If you do, bleeding may occur that is more difficult to control without more adequate exposure.
3. Remove only superficial tissue and clots. The sphincter muscles are close by. Your post-operative dressing will control the venous ooze but it may not control the small artery in and near the muscle.

If the clot is adequately removed, bleeding is minimal or easily controlled with pressure. If you see more bleeding than desired, clamp and tie or superficially electrocoagulate the area. Excessive electrocoagulation greatly increases postoperative discomfort and healing time.

---

\*Read before the Sections on Gastroenterology and Proctology, and General Practice, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 8, 1972. This work is from the Division of Colon and Rectal Surgery at Mountainside Hospital, Montclair, New Jersey.

The wound dressing consists of a cotton ball with a bolus of Xylocaine® Cream 5 per cent directly on the wound. Several 4x4's are folded into the intergluteal fold and then covered with two sanitary napkins; they are then taped in place. The patient is given printed postoperative instructions (Figure 1), a prescription for analgesics, and told to return in ten days. It is important for the patient to take an analgesic before the local wears off. They are told to go home and lie down for several hours. Frequently they are able to go to full activity the following day.

### FIGURE 1

#### *Instructions Following Excision of Thrombosed External Hemorrhoid*

1. A thrombosed external hemorrhoid is either a clot developing in a varicose vein on the outside of the anus, or a rupture of such a vein with blood accumulating beneath the skin. What has been done today is to completely excise the skin over the clot as well as the clot itself. It is important to realize that you have not had a hemorrhoidectomy performed in the office.
2. It will take approximately 7 to 10 days for the skin wound to heal. DO NOT be alarmed if bleeding or discharge occurs during this period of time as it is normal.
3. You should go home and lie down immediately for a period of 6 to 8 hours.
4. Remove the dressing at ..... and take a hot bath for 15 minutes. Repeat the bath at ..... Thereafter take a hot bath twice daily for one week.
5. Purchase 1 box of Tucks. Apply Tucks to the anal area in between the baths.
6. Beginning tomorrow insert a Vitamin A&D suppository into the rectum twice daily. Purchase 1 dozen of these suppositories. No prescription is needed.
7. It is important to keep your bowel movements soft for a period of 7 to 10 days after this procedure. Take 1 to 2 tablespoons of Mineral Oil daily, or 1 tablespoon of Milk of Magnesia as needed nightly for 1 week.
8. It will take approximately 1 to 2 hours for the local anesthesia that was administered to wear off at which time pain may be experienced for a period of 2 to 3 hours. For this reason you will be given a prescription. Have this filled immediately and take 2 tablets on arriving home and 1 to 2 tablets thereafter as needed for pain.

### Thrombosed Internal Hemorrhoid

A thrombosed internal hemorrhoid is a clot in or surrounding those varicosities or hemorrhoids covered with rectal mucosa. It is proximal to the dentate line. A swollen nodule

that may be bluish or bright red may be seen.

Thrombosed internal hemorrhoids are usually not painful, however, unless they are prolapsed outside in the anal canal or unless the clot extends across the dentate line. If concomittant external thrombosis is present, they may be the cause of the pain. Marked edema of the external hemorrhoidal area is frequent.

Thrombosed internal hemorrhoids that are causing pain must then be carefully examined to find the additional factor causing pain. Prolapse, extension across the dentate line or concomittant thrombosed external hemorrhoid or combinations of these factors will be found. A thrombosis in an external hemorrhoid should be excised as previously explained. A clot that extends across the dentate line is called a mixed thrombosis and should not be excised. A regimen for rapid relief would include Alka Butozoladin® 200 mg three times daily after meals for six doses. A stool softener, sitz baths, and a cortisone suppository twice daily completes the treatment. Rapid relief occurs over several days. Resolution for complete examination is usually present in two weeks.

A thrombosed hemorrhoid, if prolapsed, must be returned to the rectum and helped to remain there. The area and swollen hemorrhoids are injected directly with 5 to 10 cc of Xylocaine® 1 per cent with adrenalin 1 to 100,000 and Wydase® 150 Tr. units. Massage the area immediately after injection; edema disappears and the hemorrhoid is easily reduced. A Hirschman anoscope is inserted and a Baron rubber band ligation is placed proximal to the clot. This will hold the clot from prolapsing. The regimen of Alka Butozoladin®, cortisone suppository, stool softener, and sitz bath is prescribed. The patients are evaluated in ten to fourteen days. If definitive surgery appears indicated, it is recommended.

### Anorectal Abscess

Abscess formation in the lower rectum and anus is a common occurrence. Whether it occurs as a result of a break in the skin, an

infected hematoma, or as the manifestation of an infected peri-rectal gland is not critical to the relief of the pain. The incidence of abscesses is much greater in men than in women (about 4 to 1). It is not unusual in young children. Abscesses may occur internally or externally. Symptoms vary according to the size and location of the abscess.

Diagnosis in the majority of cases is straight forward. There is a visible swelling with tenderness and induration. Fluctuation may or may not be present. Edema of the overlying soft tissues may be present. Some of the internal abscesses are more subtle and may present with pain only.

Anorectal abscesses cannot be expected to clear up with nonsurgical management. Nor is it necessary or wise to wait for fluctuation to appear before intervening. Most anorectal abscesses should be incised and adequately drained as soon as the diagnosis is made. Many colon and rectal surgeons will elect to drain the abscess and treat the offending crypt area at the same time. This fistulous abscess surgery requires hospitalization and treatment in the operating room.

These patients may be safely and effectively given relief of their pain by incision and drainage under local anesthesia in the office. The most red, tender, and indurated or fluctuant area is injected intradermally with Xylocaine® 1 per cent adrenalin 1 to 100,000. A cruciate incision is made in the injected area. The exudate is aspirated with your suction apparatus. The edges are trimmed off so that an opening remains for adequate drainage. Several gauze pads and sanitary napkins are taped over the wound. The patient is given printed instructions (Figure 2) as to the postoperative management and analgesia. Appropriate follow up care is scheduled.

The patient is seen when the wound is quiet and a complete evaluation including sigmoidoscopy is accomplished without pain. If a probe can be passed through a definite fistula, hospital surgery is recommended. If not, a

## FIGURE 2

### *Instructions Following Incision and Drainage of Perianal Abscess*

1. Remove dressing at ..... and take a hot bath in water for 15 minutes.  
Repeat at ..... and thereafter take a hot bath twice daily.
2. Apply cotton to the anal wound followed by a sanitary napkin. You can expect a bloody foul drainage for a period of 1 to 4 days.
3. Keep bowels moving daily. Take a tablespoonful of Milk of Magnesia nightly as needed.
4. Take a Fleet Enema one hour prior to your next visit.
5. Have the prescription filled. Take 2 tablets immediately on arriving home. Go to bed and stay there until you take your first hot bath.

“wait and see” attitude is adopted. If no further symptoms occur, nothing else is done. With this technic the patient is given rapid relief. Both the patient and physician do not have to rush to the hospital at an inconvenient time. Beware of anorectal abscesses in the young as being a harbinger of granulomatous, ileocolitis or other systemic disease.

### Pilonidal Sinus: (Cyst)

Pilonidal cyst is a postanal sinus tract. It seldom presents itself until infection has occurred. A typical history is that a young adult develops pain at the base of the spine. A swollen reddened abscess bursts or is incised. Drainage ceases after a few days but an indurated area may persist for a week or more. After several weeks or months the process repeats itself until definitive therapy is accomplished.

Examination findings in the postanal region are characteristic. In the midline about two inches posteriorly to the anus, there is usually an opening or several openings. Hair is frequently protruding from the openings. There are frequently other openings or indurated areas off to one side. Palpation reveals induration between openings and perhaps a soft cystic area. There is most often an absence of induration between the sinus opening and the anus. A probe inserted into the tract will go toward the head rather than toward the anus. Other clinical features are: (Figure 3).



### FIGURE 3

Average age of onset of symptoms: 21½  
Average age at admission to hospital: 25  
Age distribution: Few cases under 17; maximum of 19; steep decline after 25  
Sex incidence: 73.7 per cent males  
Race: Rare in negroes  
Bodily type: Majority dark hairy subjects, but occurs also in blonde, hairless types  
Trauma: Apparently an exciting factor.  
Associated congenital defects: Rare, only 1.8 per cent.

If a patient shows a red, painful swelling in this area, the diagnosis is usually obvious. Simple emergency treatment will make the patient comfortable and in small lesions is frequently curative. The immediate area around the lesion is shaved. Local anesthesia is accomplished with Xylocaine® 1 per cent with adrenalin 1 to 100,000.

With a large abscess only the roof is injected intradermally. A cruciate incision is made and the edges are trimmed to permit adequate drainage. Several sitz baths a day are all the postoperative treatments required. Future definitive surgery will be necessary.

For a smaller abscess, field block type of local anesthesia with the same agent is used. A small wheal is raised above, below, and on either side of the abscess and tract. Inject the agent between the wheals and underneath the lesion. Pass a probe into the sinus tract to the abscess and open the tract and abscess. Evacuate the purulent exudate. Saucerize the edges. Scrape the dirty granulation tissue off. Do not remove the thick white tissue at the base. If scraped clear and left intact the wound is much less painful and heals more rapidly. A piece of Gelfoam® is placed on the wound and a dressing is applied. Analgesia is prescribed. The patient is then instructed (Figure 4) to remove the dressing and begin sitz baths the following day. Better and more rapid healing occurs if this raw surface is kept clean. Application of Furacin® soluble powder or Neosporin® powder directly into the wound twice daily is of great assistance. More recently a 0.5 per cent solution of silver nitrate-soaked gauze pad directly into the wound twice daily has been used. The patient is then seen weekly in the office.

The area is shaved. Redundantly, granulation tissue is removed. The surface is cauterized with 10 per cent silver nitrate. Frequently this is definitive therapy and no future surgery is necessary. Disability and discomfort are usually minimal.

### FIGURE 4

#### *Pilonidal Sinus Instructions*

1. Shave area once a week.
2. Spread buttocks and allow warm shower to gently cleanse wound twice daily.
3. Apply \_\_\_\_\_ twice daily directly to wound.
4. Avoid any activity with repetitive bouncing to operative area (horseback riding, bicycle, motorcycle, long car rides, etc.)

### Fissure in Ano

A fissure is a cut or tear in the lining of the anal canal. It occurs distal to the dentate line. About 90 per cent of them occur posteriorly and about 10 per cent occur anteriorly. The fissure is usually single and is caused by trauma. The common cause is overdilatation of the canal in the act of passing a large hard dry stool. Patients with anal stenosis from long use of cathartics or postoperative scarring tend to tear the lining more easily. Lichenification of the skin, as seen in pruritus ani, also is less resilient and tends to get fissures more easily.

Multiple and lateral fissures occur in young children and should be treated in the usual manner. Multiple or lateral fissures, occurring in older children or adults, demand a thorough investigation for other causes, such as Crohn's Disease, tuberculosis, venereal diseases, sexual trauma, or tumor. Between the ages of 3 and 35, be alert to rule out Crohn's Disease.

Pain related to defecation is the characteristic symptom. This pain is often extremely acute and is frequently felt for prolonged intervals after the bowel movement. The pain may be described as tearing, cutting, or burning in character. Bleeding and a serous discharge may accompany pain.

Examination may be possible only with some

effort to diminish the pain. Local infiltration (with long or short acting) anesthetic agents are effective. A cotton tip applicator liberally applied with 5 per cent Xylocaine® ointment inserted into the anal canal for several minutes will enable an examination to be performed. The diagnosis is then confirmed before starting treatment. Frequently the triad of the distal skin tag, fissure, and proximal hypertrophied papillae are present. A sigmoidoscopic examination, of course, is completed.

### FIGURE 5

#### *Instructions for Treatment of Fissures*

A fissure is a cut or tear in the lining of the anal opening. This treatment is successful in healing most fissures. It is important to continue all the treatments until instructed to discontinue them. Purchase the following medications:

Vitamin A&D suppositories  
Metamucil or L.A. Formula

Treatment: Insert one suppository morning and evening. Take 1 teaspoon of Metamucil morning and evening. Sit in hot tub morning and evening.

About 70 per cent of fissures can be healed with conservative management. This consists of a bland suppository, sitz baths, and a bulk type laxative twice daily. The suppository is not to cause a movement but rather it melts in the rectum and lubricates the stool for passage across the sore anal canal. The bulk laxative is to insure a soft-formed movement.

506 Ridgewood Avenue

As the cut or tear sits right on the internal sphincter muscle, the body tries to immobilize this sore area by going into spasm. The hot sitz bath aids to relax this muscle and significantly reduces pain.

In the acute phase this simple therapy may need some assistance. A long-acting injected local anesthetic is preferred by some. A tube of Xylocaine® ointment 5 per cent may be prescribed for local application and helps over the acute stage. A tranquilizer with muscle relaxant properties, like Valium®, may be expedient. Analgesics may be prescribed. If chronic or recurring, surgery is indicated.

### Summary

Almost all practitioners commonly see painful anorectal conditons. Significant relief can be afforded these patients with a minimum of equipment and usually without an immediate trip to the operating theater. Thrombosed external and internal hemorrhoids, fissure in ano, ano rectal abscess, and pilonidal abscess have been briefly presented with some suggestions for rapid relief of symptoms.

### Reference

Goligher, J. C.: *Surgery of the Anus, Rectum, and Colon*. Charles C. Thomas, Springfield, Illinois, 1970.

*Acknowledgment*—I am deeply indebted to my mentor, Eugene P. Salvati, M.D., for much of the material in this paper.

## Society of Clinical Hypnosis

The New Jersey Society of Clinical Hypnosis is a component of the American Society of Clinical Hypnosis. It is recognized as a related professional society by the American Dental Association and as a specialty society by the American Medical Association. It admits only licensed physicians, dentists, and doctors of psychology to membership. The Society believes that hypnosis is a valid adjunct to medical, dental, and psychologic treatment when

used by trained doctors within their fields of competence.

If you would like information about membership or would be interested in receiving competent professional training in clinical hypnosis, write or telephone the New Jersey Society of Clinical Hypnosis, 460 Bloomfield Avenue, Montclair, New Jersey 07042. Phone: (201) 746-1952.

# THE COLD RUSH OF '72

Meet it with **Cerose®** for coughs of colds



*Exempt Narcotic*

**CEROSE®** for relief of coughs due to colds, whenever an antitussive formulation having sedative, decongestant, antihistaminic, and expectorant actions is required

Each 5-cc. teaspoonful contains: codeine phosphate, 10.0 mg. (*Warning:* May be habit forming); phenindamine tartrate, 10.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, grape-flavored base, alcohol 2½%

*Non-narcotic*

**CEROSE-DM®** for relief of coughs due to colds. It diminishes the cough reflex, promotes expectoration, and provides effective vasoconstriction and bronchodilatation. Contains non-narcotic dextromethorphan

Each 5-cc. teaspoonful contains: dextromethorphan hydrobromide, 10.0 mg.; phenindamine tartrate, 5.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, mixed fruit-flavored base, alcohol 2½%



*Exempt Narcotic*

**CETRO-CIROSE®** for relief of simple coughs where a plain sedative-expectorant is required. An excellent vehicle for many other commonly employed adjunctive cough medications, as preferred by the physician

Each 5-cc. teaspoonful contains: codeine phosphate, 5.0 mg. (*Warning:* May be habit forming); fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, cherry-flavored base, alcohol 1½%

**IVES LABORATORIES INC.**

New York, N.Y. 10017



DEDICATED TO IMPROVING THE QUALITY OF LIFE, THROUGH MEDICINE



*In this compact form, a veritable manual is offered the physician to an athletic or sports team.*

# The Physiologic Basis of Training and Conditioning of Athletes

---

**Max M. Novich, M.D./Perth Amboy\***

Competitive sports make a tremendous demand on the physical condition, vitality, endurance, and mental powers of the participant. Only athletes in top condition can withstand the wear and tear of a competitive season; only the fittest can play to the best of their ability. Athletes not in condition are prone to injury or "going stale" and may never make the team. How do we prepare an athlete for maximal performance, as well as protect him from the inherent risks and hazards of these endeavors? This covers a wide spectrum of factors including nutrition, musculoskeletal and cardiorespiratory activities, water and electrolyte balance, and others. Goals of training and conditioning are to develop an athlete so that he can perform with power and speed and, at the same time, gracefully overcome the challenging tasks that confront him as he simultaneously delays the onset of fatigue which is the great equalizer among athletes. This is done by gradually increasing (with improved training results) the amount of work that is done during each practice period. I dwell mainly on this phase of the training and conditioning program although it must be realized that other aspects of the program are equally important in the over-all integrated preparation of the athlete for his sport.

Each sport makes specific demands on the body because each has its particular loads, duration, tempo, and patterns which are not

interchangeable with any other athletic activity. Thus, a football player might not last one round with a boxer, or a wrestler might find himself too "tight" to play tennis well. This requires that athletes train differently to acquire the moves, pace, and tempo that will enable them to participate effectively in a given sport. However, some general physiologic principles apply to all sports. No part of a training and conditioning program should be inimical to an athlete's health. I have in mind the nefarious practice of "crash dieting" to make a lower weight which is so common in wrestling and boxing. I am also referring to the use of anabolic steroids to help weight lifters, football players, and others to "gain weight."

The physiologic basis upon which an athlete prepares for a sport by training and conditioning is a medically sound mind and body. No course of training and conditioning for any sport should begin until a detailed preseason history and a meticulous physical examination have been performed. Although it is desirable to have a physician familiar with athletics and sympathetic to sports do such an examination, this is not a prerequisite; any competent doctor can do it. In addition, all laboratory and electro-diagnostic adjuncts which he feels are necessary should be performed. The physician must refer to a consultant whenever he finds a clinical condi-

---

\* Dr. Novich is Clinical Associate Professor of Orthopedic Surgery, College of Medicine and Dentistry of New Jersey.

tion beyond his scope of training and experience. In this manner, he can determine the physical fitness of an athlete, and eliminate those who are unfit for a sport.

The primary purpose of training and conditioning is to enable an athlete to reach a high level of athletic efficiency. To achieve this, the functions of the heart, lungs, muscles, joints and nervous system must be integrated and coordinated. Equally important is the motivation of the athlete that caused him to come out for the team. Not only must the athlete strive to attain a physical toughness to withstand the rigors and risks of his sport, but he must also be mentally tough to enable him to disregard being uncomfortable and overly cautious. It is in this area that the coach can show how great he really is; more than anybody else, he can fire up an athlete's desire to train and become prepared for the sport athletically, physically, and emotionally.

It is the coach's responsibility to enhance and develop, in a constructive manner, the compulsion that causes boys to go out for a team. Once a coach can convince his athlete that 100 per cent involvement in his training program is the only proper way to participate in athletics, the daily arduous chores of the training and conditioning program will not become a drag to the athlete. There is no short cut to getting in shape and physically fit for a sport. It takes many hours of repeated exhausting effort.

A training program aims to get an athlete into a condition where he can make specific musculoskeletal movements efficiently and repeatedly without becoming fatigued. If fatigue does set in, a quick recovery can be anticipated.

An athlete must have sufficient strength to perform the difficult and complex skills required for meaningful competition in his sport. While strength is being developed, so are speed and endurance by adaptive responses of the cardiovascular and respiratory systems for the musculoskeletal demands of the

sport. This progressive development of strength, speed, and endurance is accomplished by the physiologic overload principle. Only through strenuous exercises and athletic participation can an athlete reach his best playing form. When his arms and legs begin to hurt, he knows they are being strengthened. The heart muscle shares in the benefits of the overload principle. It beats more slowly and efficiently and delivers a greater volume of blood with each stroke. The capacity of the lungs is also increased by utilizing many dormant alveolar sacs and by the development of accessory muscles of respiration. Consequently, more oxygen is supplied to the blood, and the removal of waste metabolites produced in muscle contractions is more efficient.

Conditioning the cardiovascular and respiratory systems should be the first order of business in every training program. Associated with this is the development of the legs in running, which is used mainly to get the heart-lung-musculoskeletal complex to a level of endurance so that the other necessary components of strength, agility, and flexibility can be developed and integrated.

### Endurance

Endurance is developed by long distance running, interval training, and circuit training.

### Running

Running remains the best way to develop endurance in a boxer. As Charley Goldman, trainer of Marciano, once told me, strengthening the legs also "cleans out the lungs;" it is still an excellent method of developing "wind" in athletes. Running one to three miles daily before breakfast or during a regular work-out period is the best way of developing efficient cardiovascular and respiratory systems for a sport. However, some of our modern coaches have resorted to the following methods for developing endurance.

### Interval Training

Interval training originated in Europe as a scientific method of developing speed and en-

duration in trackmen. It is a method of overloading the athlete by use of aerobic and anaerobic exercises and the production of states of high oxygen debt. A quick recovery of the cardiovascular and respiratory systems is sought for and expected. In this method a runner runs a prescribed course in a specified time for a prescribed number of times. Fast runs are interspersed with short distances, up to a quarter of a mile. In this manner the athlete becomes fatigued many times in a training session, depending on his fitness and his ability to handle many states of high oxygen debt. Thus, he is able progressively to increase his endurance by progressively stressing the cardiorespiratory system. This type of training may also be used for football, soccer, basketball, and other sports using shorter distances or sprints.

### Circuit Training

This method was devised by G. T. Adamson and R. E. Morgan of Leeds University, England. An arrangement of exercise is performed systematically and repeatedly as a circuit, then repeated twice more as a circuit. Circuit training is based on sound physiologic principles and aims at providing varied activities and a continuous challenge.

It is a scientific arrangement of known and proved exercise, designed to elicit maximal over-all training effectiveness. Total balance development for all parts of the body is the objective. A circuit may consist of the following exercises:

1. Steps on and off chair
2. Trunk curls
3. Hops 25 yards on alternate legs
4. Dips between chair backs
5. Squat jumps
6. Press-ups
7. Sit-ups and twists
8. Squat thrusts
9. Shuttle run
10. Dorsal lifts, supported by a partner

A circuit utilizing proper exercise and equipment will:

1. Improve muscular strength and endurance, cardiovascular endurance and flexibility
2. Provide balanced development to the whole body
3. Enable large numbers of performers to train at the same time, each according to his individual capacity
4. Allow each individual to acquire a maximal workout in a short but adequate time
5. Inspire motivation through the variety of activities offered as well as by the application of new goals which become readily apparent almost daily

Because of the strenuous nature of the exercises, circuit training is usually done at the end of a training session, and should not last more than 20 minutes.

### Weight Training

In the past decade, development of strength by weight training methods have taken on unprecedented dimensions. Muscular endurance as well as muscular strength is expected. In contact sports, a well-muscled body is good protection against the bumps and bruises that are experienced. The concepts of isometric and isotonic exercise programs are bandied around glibly by the athlete and the supervisory athletic personnel. The words *explosive power* in association with weight training programs give a vivid description of the kind of body force that is anticipated when an athlete plays football. The words have a motivating influence on the type of performance that is expected.

Muscles grow larger and stronger only when required to perform tasks that place loads on them over and above previous requirements. This is the overload principle, which is the rationale for all progressive resistance exercise systems. Fears that weight training might make an athlete "muscle-bound" are groundless. This will happen only if the athlete consistently exercises muscles or muscle groups in a fixed position that will not permit a complete range of motion. That is why isometric and isotonic exercise programs must both be used by an athlete. As skill is developed, wasteful movements eliminated, and



tension in the antagonistic muscles reduced, training increases the strength of movements.

Only through hard work can an athlete develop his strength potential from a weight training program. Muscular strength is the ability to contact and overcome a specified resistance without injury to the muscle. This is developed best when resistance is high and the number of repetitions is low. Muscular endurance is the ability of a muscle to either maintain maximal contraction or to respond repeatedly for a long period of time. Both of these aspects of muscular activity are necessary.

The athlete should start with a general body building program during the off-season. During the preseason, he must focus on the muscle groups most involved in his sport. However, the athlete should not overdevelop one set of muscles which might cause an imbalance of the antagonistic muscle groups—this could cause an irregular, segmental type of joint movement. Since there has been such a decline in the strength of the shoulder and upper extremities, because of our push-button automated culture, most weight programs are directed to building up strength there as well as in the legs. In football this program is a "must" in high school athletics for linemen and for backfield men who may be a little under-developed.

The weight training program is only as effective as the amount of time and overloading used by the athlete. The amount of weight to be used is to some extent a matter of trial and error. As a guide, the following are listed:

<i>Exercise</i>	<i>Weight</i>
Two arm press	One quarter of body weight
Two arm curl	Ten pounds less
Bench press	Ten pounds more
Back and leg exercise	Half of body weight

Or one could take the maximum weight that one can lift, reduce it to 50 per cent and lift 10 times; then lift three quarters the maximum weight 10 times; then lift the max-

imum weight 10 times; then add additional weight. These are exercises done in series of six with three repetitions allowing them ten seconds for each exercise.

However, each athlete must try out these exercises for himself and adapt them to his needs. For these exercises to be effective, the athlete's muscle must be loaded near the threshold of fatigue. Both isometric and isotonic exercise programs must be used. Isometric exercises are not a substitute for isotonic exercises, which are more meaningful. Be careful when pressing in the overhead position, since this could lead to back injury.

Some of the exercises that can be used are:

Dead lift	High press	Full squat
Low pull	Bench press	Power cleans
High pull	Toe rise	Leg press
Low press	Half squat	

Weight training cannot be substituted for running. It may be used as a substitute for calisthenics, although I don't think this is a good practice. Some coaches have the athletes warm up with calisthenics before doing a little weight work. During the season, weight training should be used sparingly. However, it can be used as a supplement to regular workout activities, about once a week to maintain strength and endurance which can be lost during the season.

### Flexibility Training

One has only to watch football players to realize the unusual positions into which joints are sometimes forced. Unless the adjoining muscular and ligamentous tissues have been sufficiently stretched, one or both of these will sprain or tear and be followed by a subluxation or dislocation. Flexibility training is a process of passively stretching these tissues beyond their normal limits to prepare them for the dynamic forces to which they will be subjected.

This flexibility or suppleness is desirable to facilitate muscular action with minimal resistance of the tissues. Perfection of movement is what we strive for, and flexibility or sup-

pleness assists in achieving this. As we get older, we become less flexible, especially in the shoulders, knees, and low back, but also in other principle joints.

Flexibility is best achieved by slow controlled bobbing methods rather than by lunging exercises. Controlled movements using pain as an indicator are less likely to go beyond the extensibility of muscle tissue. Calisthenics are an excellent way of improving flexibility while also improving strength and endurance. The following exercises are excellent for most sports: Groin stretching, jumping jacks, trunk rotation with alternate toe touches, push-ups, sit-ups, and neck bridging. Even deep knee bends can be done about ten times daily without incurring any damage to the ligaments of the knee, provided no weight is carried during the exercise. Doing more than ten repetitions with weights would lead to ligamentous injury and instability. If a coach is "gung ho" on some weight training exercises for his team, it is best to do them after calisthenics.

### Reaction and Agility Training

These are exercises designed to shorten the time between stimulus and response. The idea is to make the musculoskeletal system move almost automatically in response to a stimulus, in a sense, so that each "muscle has its own mind," thus bypassing the brain. Reaction training and agility training are combined to increase mobility. Exercises such as stance and starts, run touch ground, run circles, running backwards, crab circle, four point crab, wave drill, one quarter eagle

drill, carioca drill, quick starts, and others done over and over again reduce reaction time and develop agility.

### Heat Training

This is utilized to induce favorable adaptation in the temperature regulation mechanisms. Heat training improves resistance to the high temperatures of endurance efforts, causing increased salt retention in spite of sweating. The water and electrolyte balance of the body is affected by heat, such as that generated by muscular activity, external temperature, humidity, and ventilation. Reducing the amount of clothing and lessening physical activity also help to stabilize body temperature. Warm weather, heavy uniforms, and prolonged play without rest, water, and salt may lead not only to a loss of weight, but also loss of life. Water and salt must be available to the athlete whenever he feels the need. Lack of attention by coaches to this form of training and acclimatization can lead to pathologic states of heat cramps, heat exhaustion, and heat stroke.

### Balanced Program

No single aspect of the program must be over-emphasized. No single exercise or regimen of exercises must be over-emphasized. No single apparatus provides total balanced development for all parts of the body. No single sport can accomplish total body development, although I think swimming might come close to it. Fitness for a sport requires months of careful planning, self-discipline, and hundreds—even thousands—of hours of hard work.

313 State Street

**Patronize Our Advertisers**  
**They Merit Your Support**

# Upjohn's low-priced erythromycin



**E-Mycin<sup>®</sup>**  
(erythromycin, Upjohn)  
Available in 250 mg tablets

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2141-6



# Multiple Myeloma with Myeloid Metaplasia

**Norman D. Corwin, M.D./Westwood**

The association of plasma cell myeloma with the myeloproliferative syndromes is provocative on theoretical grounds. Cases of multiple myeloma with concurrent polycythemia vera and multiple myeloma with concomitant myelofibrosis and myeloid metaplasia were reported by Brody *et al*<sup>1</sup>. The present case of multiple myeloma with concurrent development of myeloid metaplasia lends further credence to the theory of a common origin of these disorders; this patient may have had "spent" polycythemia vera as well.

A 58-year-old male was admitted on September 19, 1968, with diarrhea of ten days' duration. He had noted the onset of chills, fever, and myalgia two days prior to admission. No bloody bowel movements had been noted. Past history was unremarkable. However, he had been troubled by a cutaneous ulcer on his back for at least seven months. The blood pressure was 136/70, pulse 64, and temperature 101 by mouth. He was pallid and complained of diffuse myalgia and abdominal cramps. Abdominal examination revealed diffuse tenderness but no enlargement of liver or spleen. Rectal examination was normal. On the back, there was 1.5 centimeter ulceration over the left scapula; it had the appearance of a skin malignancy.

Laboratory data included a hemoglobin of 9.5 Grams hematocrit 28 per cent WBC 6,500 with 58 per cent neutrophils, 40 per cent lymphocytes, 2 per cent eosinophils, ESR 12 mm/hr, reticulocyte count 0.9 per cent, urinalysis unremarkable, BUN 12, FBS 115, calcium 8 mg per cent, total bilirubin 0.6 mg per cent, total protein 6.5 Grams, albumin 3.3 Grams, globulin 3.2 Grams, uric acid 5.7 mg per cent, alkaline phosphatase 7 K-A units, serum protein electrophoresis normal, serum iron 18 mcg per cent, TIBC 206 mcg per cent. Stools revealed trophozoites of amoeba histolytica and were positive for occult blood. Chest x-ray was normal. Barium enema showed minimal submucosal ulceration in the distal descending colon and multiple calcifications in the right upper quadrant indicative of cholelithiasis.

He was treated with emetine, tetracycline, chloroquine, and iodoquine in sequence and promptly improved. A hematologist reported that the peripheral blood

revealed neutrophils which were mostly bands and showed toxic granulation, rare myelocytes, Pelfer Huet cells, and a few atypical lymphocytes. Rare normoblasts, tear drop red cell forms, and hypochromia were also present. A bone marrow aspiration revealed many young plasma cells consistent with either severe reaction to infection or multiple myeloma. A radioactive liver scan proved normal. The skin lesion, a squamous cell carcinoma, was removed. He was discharged on the twenty-second hospital day.

Following discharge, the patient's anemia was refractory to iron therapy. He was re-admitted in January, 1969, with fatigue and marked pallor. The spleen was 2 centimeters below the left costal margin. Hemoglobin was 10.5 Grams, hematocrit 30 per cent, WBC 17,000, reticulocyte count 6.8 per cent, platelet count 122,000, direct Coombs' negative, haptoglobin less than 25 mg/100 ml (indicative of hemolysis), leukocyte alkaline phosphatase 87 (normal 30 to 70). Bone survey failed to reveal any evidence of destructive changes. We then learned that the patient had been called "Red" years ago because of his ruddy complexion. It seemed possible that myeloid metaplasia had developed in a patient with "burned out" polycythemia vera. He was given folic acid, 5 milligrams t.i.d., and discharged.

He was re-admitted two months later with a probable splenic infarction. The liver was depressed 2 centimeters below the costal margin and the spleen 3 centimeters below the left costal margin. Hemoglobin now was 8.1 Grams, Hct 24 per cent, WBC 8,500, reticulocyte count 6.2 per cent, platelet count 132,000, Coombs' test negative, total protein 8.0 Grams, albumin 3.6 Grams, globulin 4.4 Grams; serum protein electrophoresis now showed a gamma G monoclonal gammopathy. Bone marrow aspiration exhibited 53 per cent plasma cells arranged in sheets and displaying frequent mitoses consistent with multiple myeloma. Liver biopsy revealed no abnormalities of the liver cells themselves. The portal triads were crowded with white blood cells which had large granular nuclei; some of them contained nucleoli. These were interpreted as immature myeloid cells. There were a few smaller cells with very dense nuclei which had the appearance of lymphocytes. The picture was held compatible with intrahepatic myeloid metaplasia. He was treated with blood transfusions, prednisone, and Alkeran® and was discharged.

He was re-admitted seven months later with a hemoglobin of 6 Grams and right upper quadrant pain together with epigastric distress. Upper gastrointestinal series proved normal, but he was treated with antacids, antispasmodics, and a bland diet. At this time, the liver edge was depressed 2 centimeters below the left costal

margin and the spleen was 5 centimeters below the costal margin. He was transfused to a hemoglobin of 10.1 Grams and discharged, only to be readmitted one month later with a hemoglobin of 6.9 Grams. He received 3 units of packed cells. Bone marrow showed even more myelomatous invasion. He was treated again with Alkeran®, depo-testosterone, and prednisone and discharged. He was readmitted on December 26, 1969, with marked anemia. Bone survey revealed large lytic lesions of the skull and left clavicle. He was transfused and discharged from the hospital on a regimen of prednisone, sodium fluoride, and Cytosan®. He was readmitted on Feb. 9, 1970, for management of intense arm and leg pains. The liver and spleen were even larger than previously noted. The hemoglobin was 8.4 Grams, hematocrit 25 per cent, WBC 8,300, platelets 80,000. He received 4 units of packed cells and was discharged. He was admitted to the hospital for the last time on April 13, 1970, in a moribund state and died three days later. Permission for post-mortem was refused.

This patient demonstrated the emergence of multiple myeloma following an episode of amoebic dysentery. The myeloma was documented by the appearance of typical bone marrow changes, serum protein aberrations, and lastly, lytic bone lesions.

Following development of the multiple myeloma, hepatosplenomegaly evolved together with an hemolytic anemia requiring repeated transfusions. The peripheral blood picture of tear drop red cells, normoblasts, and immature white cell forms together with reticulocytosis was entirely compatible with that of myeloid metaplasia. The liver biopsy confirmed this as did the rising leukocyte alkaline phosphatase levels. The myeloma and myeloid metaplasia progressed independently as was evidenced by the continuing growth of the liver and spleen as osteolytic lesions of myeloma were developing.

In addition, one is tempted to postulate that he had been afflicted with polycythemia vera earlier in life and that in due course the myeloid metaplasia developed. Agnogenic myeloid metaplasia is closely related to polycythemia vera; one-third to one-fifth of all patients with primary polycythemia die from myeloid metaplasia.<sup>2</sup> Mean survival in agnogenic myeloid metaplasia was 58 months in a group of 43 patients.<sup>3</sup>

The concept of a spectrum of myeloprolifer-

ative syndromes was introduced by Dameshek<sup>4</sup>. In a more recent publication, Dameshek<sup>5</sup> revised his synthesis of the myeloproliferative disorder somewhat emphasizing growth disorders of the marrow as characterized by either increased, decreased, or abnormal growth. He comments on the paucity of protein and immunologic abnormalities, so common in the lymphoproliferative disorders, in the myeloproliferative disorders. However, he does cite instances of exceptions; (a) immunoglobulin "spikes" are occasionally seen in polycythemia vera, (b) macroglobulins including rheumatoid factor may occur in myelosclerosis with myeloid metaplasia, (c) immunologic abnormalities, including autoimmune hemolytic anemia and lupus erythematosus tests and even systemic lupus may occur in the DiGuglielmo syndrome.

Dittmar, *et al.*<sup>6</sup> reported the coexistence of polycythemia vera and biclonal gammopathy with two Bence-Jones proteins. It was suggested that there may have been a common unidentified stimulus which caused the proliferation of both red cells and plasma cells. Likewise, Brody, *et al.*<sup>1</sup> postulated that totipotent fetal stem-cells may prove capable of simultaneous divergent hematopoietic propagation. This same reasoning may be invoked to explain the occurrence in the case reported herein. Alternately, the myeloid metaplasia may be regarded as secondary to marrow replacement by plasma cell proliferation. Indeed, secondary myeloid metaplasia is difficult to separate from agnogenic myeloid metaplasia.<sup>3</sup>

Waldenstrom<sup>7</sup> cited instances of such combinations as myeloma and reticulum cell sarcoma, myeloma and lymphatic leukemia, and macroglobulinemia with lymphosarcoma or reticulum cell sarcoma. He<sup>8</sup> suggests the concept of myeloproliferative disorders be revised so as to include the immunoproliferative disorder in what he terms "reticuloproliferative" disease. The "primitive reticuloblast" he assumes has at least a dozen potentialities which he lists as: osteoblasts, osteoclasts, plas-

ma cells, mast cells, macroglobulin forming lymphocytoid cells, proliferating lymphocytes (leukemic or sessile in lymphosarcoma), reticular cells, myeloblasts, xanthoma cells, normoblasts, platelet forming cells, endothelioid cells. However, it is noteworthy that a word of skepticism has been voiced recently by Glasser and Walker<sup>9</sup> who felt that evidence of transitions in the myeloproliferative disorders is inadequate to support the concept that these diseases represent merely different parts of a spectrum of a pathologic state.

### Summary

A case in which the simultaneous emergence of plasma cell myeloma and myeloid metaplasia occurred is documented. While this relationship may be purely coincidental, it would appear possible that an unidentified stimulus provoked divergent growth of pleuripotent stem cells resulting in the development of these two hematologic disorders.

234 Fourth Avenue

### Bibliography

1. Brody J. I., Beizer, L. H., and Schwartz, S.: *Am. J. Med.* 36:315 (1964)
2. Van Dyke D., Lawrence, J. H., Anger, H. O.: Whole-body Marrow-Distribution Studies in Polycythemia Vera, in *Myeloproliferative Disorders of Animals and Man*, edited by Clarke, W. J., *et al.* AEC Symposium Series 19, U.S. Atomic Energy Commission Division of Technical Information, 1970, p. 721.
3. Ward, H. P. and Block M. H.: Myeloid Metaplasia: A Re-evaluation, in *Myeloproliferative Disorders of Animals and Man*, edited by Clarke, W. J., *et al.* AEC Symposium Series 19, U.S. Atomic Energy Commission Division of Technical Information, 1970, p. 609.
4. Dameshek, W.: *Blood* 6:372 (1951)
5. Dameshek, W.: The Myeloproliferative Disorders, in *Myeloproliferative Disorders of Animals and Man*, edited by Clarke, W. J., *et al.* AEC Symposium Series 19, U.S. Atomic Energy Commission Division of Technical Information, 1970, p. 413.
6. Dittmar, K., Kochwa, S., Zucker-Franklin, D., Wasserman, L. R.: *Blood* 31:81 (1968)
7. Waldenstrom, J. G.: *Monoclonal and Polyclonal Hypergammaglobulinemia*. Nashville, Vanderbilt University Press, 1968, p. 195.
8. *Ibid.* p. 197.
9. Glasser, R. M. and Walker, R. L.: *Ann. Int. Med.* 71:285 (1969)

### Medical Teams to Deprived Areas

The federal government has announced the first assignments of federal doctors and other health workers to provide direct patient care in rural and big city areas with critical health manpower shortages.

Teams with a total of 68 medical workers, including physicians, dentists, and nurses, will be assigned to 18 communities in 13 states to work with such patient groups as Indians, migrant workers, welfare families, and minorities. The first team, a husband-wife, doctor-nurse duo, was assigned to a 14-bed hospital in rural Jackman, Maine, in September 1971. The second team went to work in Imokalee, Florida on March 1. Sixteen other teams will be assigned.

The Corps was created December 31, 1970, when President Nixon signed the Emergency

Health Personnel Act, which calls for government health workers to provide direct health services to residents of city slums and remote rural areas designated as having critical health manpower shortages. Dr. David A. Kindig, recruitment chief for the Corps, said that the major incentive for doctors to join had been the military draft. All 28 doctors among the 68 initial medical workers were recruited from the Public Health Service (PHS) Commissioned Corps, and "many of them are still fulfilling their military obligations," he said.

The teams also include 10 dentists, 18 nurses, and 12 other professionals, including pharmacists, dental hygienists, health educators, and laboratory technicians. Recruitment of some team members, such as nurses, may be done at the local level.



## THE MEDICAL SOCIETY OF NEW JERSEY

### Professional Liability Insurance Program

#### Society Endorsed Coverages—

- Professional Liability for  
Individuals  
Partnerships and Professional Corporations  
Employed Nurses, Technicians or Aides
- Professional Premises
- Excess (Umbrella) Liability—Limits up to \$5 Million

#### Management of Loss Control Program—

- Claims Peer Review
- Prompt Advice Regarding Potential or Actual Claims
- Defense by Highly Skilled and Experienced Counsel
- Investigation by Specialists in Malpractice

### JOSEPH A. BRITTON AGENCY

15 South Munn Ave., East Orange, N.J. 07018

(201) • 673-3060

ALSO AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

## Android<sup>®</sup> 5

MUQUETS  
BUCCAL Tabs

Methyltestosterone N.F. - 5 mg.

## Android<sup>®</sup> 10

Methyltestosterone N.F. - 10 mg.

## Android<sup>®</sup> 25

Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating male for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Vaginitis in female patients • Hypersensitivity and gynecomastia

**DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized as patients vary widely in requirements. Daily requirements are administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dos. Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40
Postpubertal cryptorchidism	30

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

**BROWN**

THE BROWN PHARMACEUTICAL CO., INC.  
2500 West 6th Street, Los Angeles, California 90057



"For generations my family has insisted on Donnagel<sup>®</sup>-PG," says active young matron Mrs. T. Farnsworth Lipp (of the Upper Lipps), shown here with her charming son. "All the benefits of paregoric—without the unpleasant taste, don't you know? And Junior thinks Donnagel-PG tastes so much like bananas that I never worry about a slip between spoon and Lipp."

## *A Matter of Taste*

With or without a silver spoon, a most tasteful solution in treating acute, non-specific ailments: all the benefits of paregoric, without the unpleasant taste. Donnagel<sup>®</sup>-PG treats accompanying cramping, tenesmus, and nausea as well as the diarrhea itself. Instead of unpleasant-tasting paregoric, it contains the therapeutic equivalent, powdered opium, to promote the production of formed stools and lessen the urge. And it provides the pleasant-detoxicant effects of kaolin and pectin, plus the antispasmodic benefits of atropine alkaloids. And a good banana flavor to baby any taste.

## **Donnagel<sup>®</sup>-PG**

Donnagel with paregoric equivalent

Available on oral prescription or without prescription under limited circumstances as modified by applicable state law.

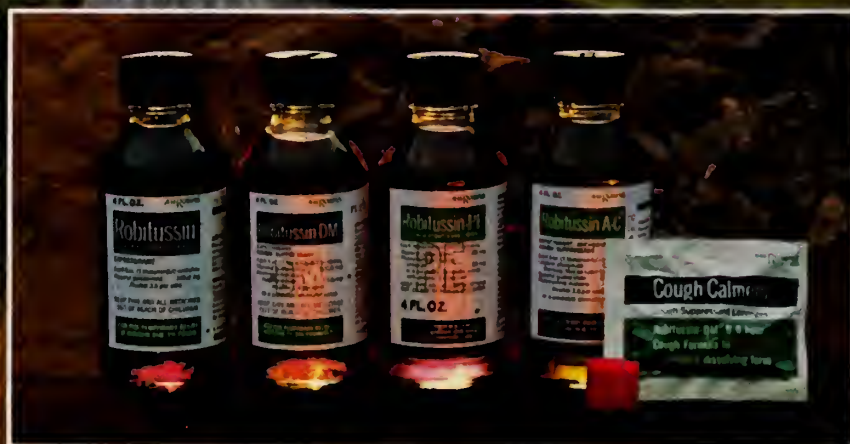
Each 30 cc. contains: Kaolin, 6.0 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (Warning: may be habit forming); Sodium benzoate (preservative), 0.5 g.; Alcohol, 5%. A.H. Robins Company, Richmond, Virginia 23220

# **A·H·ROBINS**





coughs are back...
















# clear the tract!

# with the

# ROBITUSSIN® LINE

Select the Robitussin® "Clear-Tract" Formulation That Treats Your Patient's Individual Coughing Needs:

All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the extra benefits you want for your patient.

Robitussin® extra benefit chart	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®					
ROBITUSSIN A-C®					
ROBITUSSIN-DM®					
ROBITUSSIN-PE®					
COUGH CALMERS®					

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

*For coughs of colds and "flu"*

## Robitussin®

Each 5 cc. contains:

Glyceryl guaiacolate . . . . . 100.0 mg.  
Alcohol, 3.5%

*For unproductive allergic coughs*

## Robitussin A-C®

Each 5 cc. contains:

Glyceryl guaiacolate . . . . . 100.0 mg.  
Pheniramine maleate . . . . . 7.5 mg.  
Codeine phosphate . . . . . 10.0 mg.  
(warning: may be habit forming)  
Alcohol, 3.5%

*Non-narcotic for 6-8 hr. cough control*

## Robitussin-DM®

Each 5 cc. contains:

Glyceryl guaiacolate . . . . . 100.0 mg.  
Dextromethorphan  
hydrobromide . . . . . 15.0 mg.  
Alcohol, 1.4%

*Clears sinuses and nasal stuffiness as it relieves cough*

## Robitussin-PE®

Each 5 cc. contains:

Glyceryl guaiacolate . . . . . 100.0 mg.  
Phenylephrine  
hydrochloride . . . . . 10.0 mg.  
Alcohol, 1.4%

*Robitussin-DM in solid form for "coughs on the go"*

## Cough Calmers®

Each Cough Calmer contains:

Glyceryl guaiacolate . . . . . 50.0 mg.  
Dextromethorphan  
hydrobromide . . . . . 7.5 mg.

A. H. Robins Company,  
Richmond, Virginia 23220

## A-H ROBINS



## Are they too old to swing?

### EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol .....	0.005 mg.
Methyltestosterone .....	1.25 mg.
L-lysine .....	100 mg.
Ferrous Nicotinate .....	17.85 mg.
Equivalent to Nicotinic Acid .....	12.5 mg.
Ferrous Iron .....	2.82 mg.
Vitamin A .....	2,500 U. S. P. Units
Vitamin D .....	250 U. S. P. Units
Thiamine Mononitrate .....	2.5 mg.
Riboflavin .....	2.5 mg.
Ascorbic Acid .....	25.0 mg.
Folic Acid .....	0.125 mg.
Vitamin B-12 .....	1.5 mcg.
Methionine .....	12 mg.
Choline Bitartrate .....	15 mg.
Inositol .....	10 mg.
Calcium Pantothenate .....	2.5 mg.
Pyridoxine .....	0.25 mg.
Copper (from Copper Sulfate) .....	0.25 mg.
Zinc (from Zinc Oxide) .....	0.25 mg.
Iodine (from Potassium Iodide) .....	0.075 mg.
Calcium (from Dicalcium Phosphate) ..	72.5 mg.
Phosphorus (from Dicalcium Phosphate) .....	55 mg.
Potassium (from Potassium Sulfate) ..	2.5 mg.
Manganese (from Manganese Sulfate) ..	0.5 mg.
Magnesium (from Magnesium Sulfate) ..	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

**ACTION AND USES—DOSAGE:** 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 30, 100, and 500 tablets. Rx only.

## Testand-B tablets

*A hormonal, nutritional supplement*

**Geriatric Pharmaceutical Corp.**  
Floral Park, New York 11001  
*Pioneers in Geriatric Research*



*The patient ("the consumer") has a role in the distribution of medical care these days.*

# New Challenges to Medical Care

---

**James A. Rogers, M.D./Paterson\***

Our present system for the delivery of health care is now being challenged. Let us consider why some of these challenges are before us, and let us review some of the changes that may take place.

As physicians, we are practicing the way our experience and our convictions guide us. But today, there are many external influences challenging our way of doing things. However, other professions are also being challenged in the way they too are rendering service. The external influences are the public, and the public is not satisfied with the medical care it is receiving. The government which is representing the public tends to respond to these challenges. Why is the delivery of health care presently being challenged?

1. Health care is no longer a privilege but it is a right.

2. We, as physicians, are aware of the rapid expansion of technology in science and in medicine. The general public is also aware of this through the news media, through many popular magazines, through TV programs, where actors portray brilliant young interns and doctors perform miracles, all within the period of about 48 minutes—then followed by a commercial. This has an influence on the public's thinking and before long, they are saying, "Why not?" "Why can't they provide it here and now?" These queries are raised about community hospitals.

3. The public now views medicine in a differ-

ent light than it did a few years ago. From attitudes of confidence, respect, hope, and awe, we now see that the public has great expectations and little patience with the medical profession. We are living in a time when the public cannot understand why total health care is not adequately delivered now.

4. The third party payers (Medicare, Medicaid, Blue Cross, Blue Shield, and the private health insurers) are beginning to exert strong influence on the consumer and on the providers of health care as well.

As physicians, we have learned from our past experiences. We have made attempts to apply the knowledge to the needs of the day. We have long-standing traditions. And, we have, over the years, earned the respect of the community and of our fellowman. Yet today, all four are being challenged as never before, because more is expected of us.

Today there is increased emphasis on continuing medical education which was once known as postgraduate education. Increasingly we hear about peer review, relicensure, recertification, and accreditation. We hear of the utilization of paramedical personnel, including physicians' assistants. We hear about the "team approach" to patient care. We are more aware of the community's involvement in medical affairs and we are urged, as physicians, to participate more in community affairs. Are any of the above really new?

\*From a talk to the Warren County Medical Society, April 18, 1972. Doctor Rogers is First Vice-President of The Medical Society of New Jersey and Coordinator of the Office of Continuing Medical Education of New Jersey, CMDNJ.



As physicians, we have reacted separately to all these situations. When we review these problems and challenges, we realize that we have lived with most of them to some extent. Thus, we have experienced peer review, which was exercised by our preceptors, our chiefs, our colleagues, the appointed or elected chairmen of the medical departments of the staff, and by the tissue, the medical, and the audit committees. They are forms of peer review and have to do with the quality of medical care.

Utilization review committees are involved mainly with the quantity of medical care delivered, such as hospital bed utilization, with other hospital review problems, such as the over-or-under utilization of services (laboratory tests, x-rays, consultations, and other services) related to health care. This is also peer review. And, for the past few years, we have been involved with third party payers, dealing primarily in the abuses of the cost of health care, not only by a few doctors, but by the third party payers as well. The AMA Council on Medical Services says that "Peer review is an evaluation of the quality, quantity, and the cost of patient care rendered by the physician or the providers of health care, as determined by their fellow physicians." As it exists today, peer review is not the perfect mechanism it should be. It is imperative for physicians to develop a system which would be compatible with quality medical care on a voluntary basis. Perhaps it is time for us to stop reacting and begin to act, for there is still time. The public is looking to us as the experts in health care. The public has not lost all confidence in our ability to find a solution. However, should we fail, we may have to adjust to a system not voluntarily determined by physicians.

In considering the evaluation of quality medical care, we must begin in the community hospital. Here most physicians do their problem-solving. Here the rules of conduct are set down by the medical staff and approved by the Board of Trustees. Thus it is only logical that we begin by approaching the medical staff to establish their own criteria for the evaluation of patient care. Let me stress at

this point that the criteria must be developed by the staff. It should be a corrective, as well as an educational mechanism, but not a punitive mechanism. When physicians evaluate the records in their hospital, they are in a position to determine their own capabilities and their performance more objectively. By understanding their needs, they will be in a better position to mold the educational programs in their hospital. They will be able better to decide what is necessary and relevant to resolve the problems that face them in their own community and in their own hospital. What better way can we improve the quality of patient care but by improving our abilities, our capabilities, and our performance.

Physicians' fees account for about 20 per cent of the health care costs today. The remaining 80 per cent go toward facilities and services. However, almost 100 per cent of these costs are ordered by physicians. If the utilization and the quality of health care are to be improved, a more efficient health care system would evolve, and the cost of medical care will then become a more negotiable issue.

The role of physician's assistant is not really new. Many physicians have trained nurses or technicians to work under their supervision. The status of physician's assistant is considered with mixed emotions, for the reason that it has not been spelled out as to exactly what their duties will be or how best they can function. We are not certain who will be responsible and liable for their activities, and who will compensate them. The over-all problem needs clarification. There is no uniformity of programs; there are only comparisons. The range of duties and activities of one vary from the other. The question of their certification and of their licensure is not settled in many states, including New Jersey. The pediatricians are developing pediatric assistants, and many of the specialty boards are tackling this problem, setting down guidelines for the training, duties, and responsibilities of the assistants.

Many schools, including Duke University,

have programs to develop assistants for general practitioners. Livingston College at Rutgers University was preparing a specialized, yet flexible program leading to a bachelor's degree. It was designed to train candidates effectively to carry out their duties. A physician's assistant may desire to proceed further in his studies and wish to go to medical school. Courses taken for his bachelor's degree which satisfactorily meet the requirements toward entrance to medical school, would be acknowledged. Up until three months ago, the State Board of Medical Examiners of New Jersey had not taken a stand on the matter of licensure for this group.

Team approach to patient care exists in our hospitals, and is under the direction of the physician. Individuals of the team (nurse, technician, therapist) treat the patient separately. The concept of team approach is now presented as a function in which all share in the care of the patient in a cooperative, simultaneous effort.

The government is assuming more of the financial responsibility of health care. It is becoming more involved, and there is a likelihood of even more government intervention in the future. This will reflect itself in consumer participation. We will be asked for an accounting of what is being done to improve the delivery of health care, in training physicians, as well as others needed to provide this health care. It will be necessary for us to reflect and change the present health care system to meet the demands and the challenge of society. This can best be accomplished with a system having voluntary characteristics. But voluntarism means hard work and total coop-

eration. It will not be good to have total government control. I do not think the public wants this kind of involvement as individual professional patients.

With all the time presently being devoted to patient care, with such a shortage of primary physicians or family physicians, and with the maldistribution of medical talent that now exists, one wonders where will the doctor find time to involve himself in all of the community affairs that demand his participation. Your answer here is the cooperative and coordinated efforts of the members of your medical society. The work cannot be left to a few but must be widely distributed to the many. Physicians must find the proper solution and present their case on all levels. You must do your part and become involved. We must be a knowledgeable and a united group, to act on matters which are in the best interest of the public and medicine. This means quality patient care which we strive to deliver. We must alert our legislators with the proper information necessary to carry out their responsibility of protecting the public in matters pertaining to the health of the people. Let us act, and not merely react. Let this challenge be met by physicians and practitioners, nurses, medical administrators, medical educators, and those involved in health care as professionals.

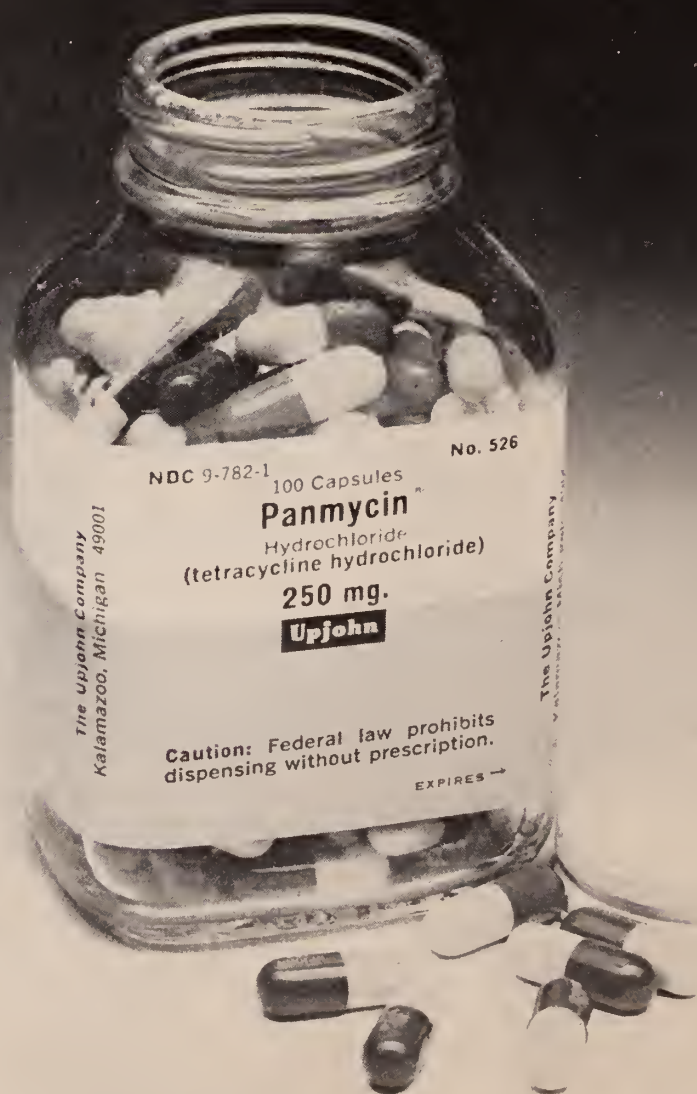
Whatever change the future may hold for our society, let us strive to retain the vestiges of the private system of health care that are worth preserving. It has been said that a healthy nation is a strong nation. A strong nation is a free nation. As physicians, we have a responsibility in the quality of the health care of this free nation.

346 East 34th Street

**Support the Society for  
Relief of Widows and Orphans**

(P.O. Box 95, Belleville, N.J.)

# Upjohn's low-priced tetracycline



## Panmycin<sup>®</sup>

(tetracycline HCl, Upjohn)

Available as 250 mg capsules and  
tetracycline syrup 125 mg/5 ml

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2142 6



*In our polyglot America, the physician is often stymied by his inability to communicate with a foreign-language speaking patient. This unique interview shows one way of resolving that communication gap.*

## Talking Pictures for Patient Contact

Jack Adams-Ray, M.D., Stockholm, Sweden  
and Fradley H. Garner, M.A., Vedback, Denmark\*

It was not the time or place to be at a loss for words. The Swedish surgeon slouched on the steps down from Red Square, his face drawn with the anguish of a suddenly separated quadriceps patellar tendon. This was supposed to be the professor's last day in Moscow where he was attending a symposium on resuscitation. He sensed more trouble ahead when he could not sum up what happened quite so concisely to the mobile physician in a magnificently equipped ambulance that came in five minutes and shot him back to Bodkin Hospital. The house officer who ushered his Swedish colleague through radiology, the plaster room, and finally to bed spoke English. But then the verbal curtain fell. The surgeon-patient and his useless eight tongues lay on one side; the floor staff and their working Russian moved on the other. He could not cut through with any of the words he knew. They could not reach him with theirs. "Body language" is not all that universal, he discovered. For the most frantic miming failed to get him a bedpan or toilet paper until it was almost too late. And that was when he got the idea for a *Pictorial Interpreter of Medicine*.<sup>1</sup>

This turned out to be a long, envelope-sized, 44-page book of cartoons (Figure 1) to help all concerned (house staffs too) out of the same fix. A number of Scandinavian hospitals now have an *Interpreter* on hand, as does, in case lightning strikes twice, its traveling creator. In a conversation tape-recorded in Stockholm, the now retired surgeon offers some observations on diagnosis and tells what the silent communicator can do for others caught behind the verbal curtain.

*Q:* Professor Adams-Ray, let me first ask you the question that everybody must ask you about your handbook, *Pictorial Interpreter of Medicine*, and that is: How did you come to think of the idea in the first place?

*Adams-Ray:* Well, there is nothing so bad that something good does not come out of it. I damaged my knee, I ruptured the quadriceps femoris tendon. I was just walking down the stairs and I just pulled it off. I made the diagnosis myself. That was in Moscow in 1968. An ambulance came in five minutes. In Moscow ambulances they have a doctor and a doctor's assistant, which we don't have in Sweden and I don't think you have in America. I was taken to the Bodkin Hospital where I got excellent care. My special doctor spoke good English, but the rest of the personnel spoke none, and I don't speak Russian.

*Q:* But you speak German?

*Adams-Ray:* Nobody understood anything other than Russian.

*Q:* How many languages do you speak, incidentally?

*Adams-Ray:* I speak Swedish, English, French, German, Danish, Norwegian, a smattering of Italian, some Polish, and a few words of Russian. But I could not make contact when it came to the small everyday

\* Dr. Adams-Ray is emeritus Professor of Surgery at Karolinska Institute in Stockholm. Mr. Garner is an American-born, free-lance medical writer now the International Editor of the American magazine *Ecology Today*.

needs. Sometimes I could show them by my hands, but most of the time I just couldn't get them to understand what I wanted. The idea came to me, by the way, when I wanted toilet paper and I could not, with gestures, show what toilet paper is. Finally, when it was almost too late, they understood the wiping movement and I got what I wanted. Such a loss of contact is hard to bear when you are lying in a hospital like that—and it can happen to anybody, even if he speaks many languages. If you travel abroad there is always the chance of landing in the hospital—one where nobody speaks your language. This can make it difficult to diagnose your condition, let alone to get things you want, and to do what the doctor and nurse want you to do. Have you ever been in a situation where you could say nothing to the people around you?



Figure 1

<p>PATIENTEN ÖNSKAR THE PATIENT WISHES LE MALADE DEMANDE DER PATIENT WÜNSCHT EL PACIENTE DESEA</p>	<p>IL PAZIENTE DESIDERA PACIJENT ŽELI Ο ΑΡΡΟΣΤΟΣ ΖΗΤΑ POTILAS HALUAA</p>

Figure 2

Q: Yes, when I first moved to Denmark and visited my in-laws who speak only Danish.

Adams-Ray: With some in-laws, not yours I'm sure, that could be a blessing. But then you can appreciate the feeling. This should have been my last day in Moscow where I was attending a symposium on resuscitation. I had many commitments at home in Stockholm. I wondered when I could catch the plane out of there. I felt helpless, not being able to ask for even the most basic things. I realized how much extra strain is put on a patient in a foreign country, when all his energies should be channeled into getting well. I realized how much this communication gap handicapped the medical and nursing staffs. As soon as I got home, I called Claes Folkesson, who is a very clever cartoonist.

Q: But back there in Moscow, it was your own needs, not the staff's, that came first? You envisioned a picture-book *primarily* for the patient?

Adams-Ray: Because the patient and his needs come first. He must make contact with the staff, first for the things *he* needs—water, a bedpan, toilet paper, sanitary napkin, communication with his embassy, a priest, a handkerchief, and so on—these are pictured first (Figure 2) in the *Pictorial Interpreter*.

Without a good diagnosis, the patient cannot be treated and unless he can answer questions and project his feelings, he cannot help the doctor make an accurate diagnosis. Case history is often indispensable for making the right diagnosis. In fact, some diagnoses you can make *only* by taking the history. In acute situations, it is essential to know *when* the pain started, *how* it started, what *type* of pain it is, and *where* it is. So that's why I have begun with the patient and then moved on to what the nurse wanted the patient to do.

Q: But the nature of *your* injury was obvious enough to you; surely this didn't require a case history?

Adams-Ray: No, but my book covers more than kneecaps. I insist on the case history because I know after 40 years of surgery that in about 90 per cent of cases you can make the diagnosis from the history alone. When you are old enough and have experienced enough, you can sometimes talk with the patient perhaps two minutes and you have the diagnosis. When the patient comes in with a pain in his hip, I ask him, "When does that pain come?" And he may say, "When I start walking." Then I know from experience that I can ask him, "Does the pain get so bad that you can't walk any longer after some 100 yards?" If he says "Yes, I have to stop." "And then the pain passes away?" Then I know it's not his hip joint but his arteries that are troubling him.

Q: Angina cruris?

Adams-Ray: There the pain is usually in the calf. If I had a pain in my chest when I inhaled, if I can't tell that to the doctor, he might fail to diagnose an embolus in my lung! Now the *Pictorial Interpreter* lets the doctor and patient talk together like this without words. In the section called "The Doctor Asks" you see (Figure 3) a man with a dagger in his arm—the point of pain—and another man with a stone dropping on his foot, and another with a hammer banging him on the head . . . pain. Under these three figures is a box with nine red stars—standing for the intensity of the pain—and you cover say, seven or eight with your hand so only a couple show, and you learn that the pain is not very intense. Or you expose eight or nine and you know it's killing.

Q: On the facing page (22-23) I see you repeat the star box with an arrow pointing right to a clock and another pointing downward to positions of the sun and moon.

Adams-Ray: That's to find out when, what time of day or night, the pain came or comes on, or whether it is constant. There is a question mark inside the clock, and the black circled numbers from one to seven at the bottom of the page stand for the day of the



week. The figure 7, notice, is red. I can't read Russian. But at the symposium I met my old friend Professor Negowsky, who is an excellent man on resuscitation. He is doing marvelous work on death—a special interest of mine—and on body cooling. He has cooled dogs down to +8 degrees centigrade—makes much more sense than Fahrenheit, and we ought to give him the credit. Negowsky cools them down, the heart stops, circulation stops, there are no signals from the brain, and he pumps away the blood and keeps dog and blood at 8 degrees centigrade for one to two and one-half hours. Later he rewarms body and blood and the animal lives again. The first to revive a man who was apparently dead from freezing was a Swedish provincial doctor in 1767. Negowsky started his work after his observations at the battle of Stalingrad. In the United States back in 1950, Bigelow was an important pioneer in the field of hypothermia.

*Q:* Anyway, you were in this hospital two days, you came out, with a cast on?

*Adams-Ray:* Yes, I flew home with the cast on and was operated on by one of my assistants in the Karolinska. But there in Moscow I felt so lonely and isolated. So I *had* to do something to help other people who get into the same situation. And these days, with people traveling around the world, the problem is much greater. I think all travel bureaus should give their clients such an *Interpreter* to take with them. In Sweden today we have thousands of foreign guest-workers especially from the Balkan countries, who know very little Swedish. Neither do most Finns here. They don't carry the booklet, but I think about 200 of our hospitals now do, and I have had many good letters and comments about it. But aliens are not the only people who may need such help. Aphasics, respirator patients, the deaf and dumb, people who can't communicate for pathologic reasons. The Norwegian Deaf and Dumb Society wrote an article about this booklet and said that every deaf and dumb person should have this medical *Interpreter* to use if he has to go to the hospital or needs medical help.

*Q:* Tell me about getting together with your artist. You knew him?

*Adams-Ray:* One of my assistants knew Claes Folkesson. He has done an extraordinary job with those pictures. It's very difficult, you see, to find symbols that can be understood by most people. You never can have symbols that all people from every society will understand, not in our time, anyway. We started working just after I came home from the hospital, the Swedish hospital, and we planned it all the way together. We decided to use plain, factual illustrations and flat, very bright color. Many of the drawings are anatomical. Very simplified. In others he used the cartoonist's technic of balloons. Balloons, but with pictures instead of words in them, and pointing to the patient's mouth if he is asking for something, or connected to his head with little bubbles, if he is thinking or dreaming about something. I think some are brilliant: a cow, for example, beside a white glass to show a glass of milk (page 5), and a carousel going round in a cartoon balloon beside this blurred man with outstretched arms (page 36)—he's dizzy. These are "talking pictures." One situation that taxed our brains was—do you say "constipation" or "obstipation?" Here on page 33, the doctor asks, "Have you moved your bowels or passed gas?" (Figure 4) That's a basic sign when you have an acute abdomen. So we show a man on a toilet in one frame passing normal stools, in the second frame watery stools, and just gas in the third frame. And then three behinds in a row with nothing coming out. Constipation.

*Q:* Without words, that's about the only way you *could* have pictured this. So the *Interpreter* can aid the doctor in many ways.

*Adams-Ray:* And the nurse! In the end we decided that just a few key words would be helpful, mainly for the four chapter headings: "The Patient Wishes," "The Nurse Says," "The Doctor Asks," "The Patient Says." These headings are listed in altogether nine languages at the top of the pages in the appropriate chapters. Now the nurse can explain things to her patient, such as, on page

18 (Figure 5), "I know you have a terrible headache, so now I am going to give you an injection—or some pills—so the pain will go away and you will sleep peacefully." Or, "No, you may not drink or eat anything now because you must have an operation." One drawing (Figure 5) shows an operation in progress, and the one before it shows food and drink crossed over in red. If she sees her patient in pain, she can ask him, "Where does it hurt you?" and the patient can quickly tell her. She can even tell the patient when he can go home—a major piece of information for someone in the hospital. She can use any other section of the book that is useful. And the patient himself can use "The Doctor Asks." Because if he looks through this book, he knows what the pain stars mean, and he can point to any part that hurts and tell us, often more accurately than with words, how

much it hurts, whether the pain is constant or comes in waves, and so on.

*Q:* But the natural thing, of course, is to point to *himself*, isn't it? I mean if I have a pain in my chest, I go like this (demonstrates) and I indicate, you know, by "body language" . . .

*Adams-Ray:* Body language, yes. But many people cannot express themselves by mimics! Chinese women, for instance, used to use small dolls for this purpose. They took the place of physical examination, too, in the old days of Chinese herbal medicine.

*Q:* Could you look at "The Doctor Asks" and lead me through a diagnosis of, say, a coronary episode? Or a patient's coronary history?



Figure 3

DOKTORN FRÅGAR  
THE DOCTOR ASKS  
LE DOCTEUR QUESTIONNE  
DER ARZT FRAGT  
EL MEDICO PREGUNTA

IL DOTTORE SI INFORMA  
DOKTOR PITA  
Ο ΙΑΤΡΟΣ ΠΙΤΑ  
TOHTORI KYSYY

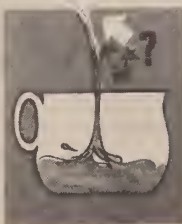
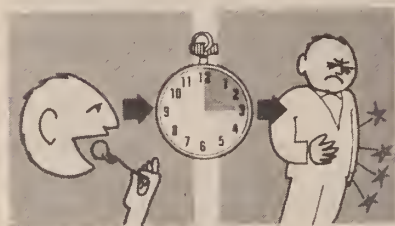


Figure 4

*Adams-Ray:* First I make sure the patient knows these stars on page 22 (Figure 3) signify pain. Then pointing to the drawing, I ask him to locate the pain. He points to his chest, or his arm, or whatever. Now I turn to this picture on page 26 and here he sees two full figures outlined, one from the front, the other from the back. Heart and lungs are shown in the front view, and the path of pain is indicated by a red line with arrows. At the top of the page are some red "pain" stars and a wavy red line so he knows we are "talking about" the path of pain. "Here is the heart," I show him, "and here is one line of pain going up the left side to the teeth. And here is another line from the heart downwards along the left arm. Does your pain go like this, both ways?" He indicates "yes." Or, *he* may take the lead and show *me* the pain goes these ways. And then I know his pain is radiating downwards and upwards. Now here on page 31 is a

heart with pain stars shooting out of it and a big question mark above. I want to know if he has had any pain before. At the bottom of this page I show him a man on a stretcher being hurried to a waiting ambulance. Three stars shoot out of the patient's heart. "Has this happened to you before?" And we can establish the onset time on a calendar if he can understand numbers. On the same page is a series of three simple heartbeat patterns, a kind of layman's EKG chart, with red hearts standing for beats. The top chart shows a regular pulse, the middle chart a light tachycardia, the bottom a severe arrhythmia. I am interested in the cardiac history, you see. I could turn to page 29 to this man inhaling and exhaling deeply through his mouth, with pain stars shooting from his chest and right shoulder.

*Q:* Would you yourself imitate this panting?



Adams-Ray: Oh, yes (panting) and you can see here from the arrows beside the mouth that it is both inhaling and exhaling. This would indicate an irritation of the pleura which is common with embolism or with inflammation of the lungs or pleura.

Q: "The Doctor Asks" seems mostly concerned with acute situations, with painful conditions.

Adams-Ray: That is basically true because, especially with a traveler, it is usually some kind of emergency or painful condition that brings him to the hospital or to the doctor. But not all the situations are so acute. For instance, a patient lets you know he has a pain in the knee (page 28). So I point to a man climbing stairs without pain (no red stars from knee) and to the next picture of him going downstairs *painfully*. "And after

you have been sitting still and then get up to walk," I let the two pictures below ask him, "You feel pain in that knee?" He affirms this. I know then that he may have arthrosis deformans of that knee. That's typical with older patients with long-standing pain like that. We do cover all the major organ systems, I think, and not the least the genitourinary tract.

Q: Gynecologic symptoms would be hard to get across with "body language" wouldn't they?

Adams-Ray: Almost impossible? Here you see drops of blood coming from the vagina of this torso drawing, and yellowish drops like discharge from the next picture, and underneath a 31-day calendar. Well now you can establish the menstrual cycle and genitourinary disorder. If you think that she might be pregnant, here at the bottom are the 12

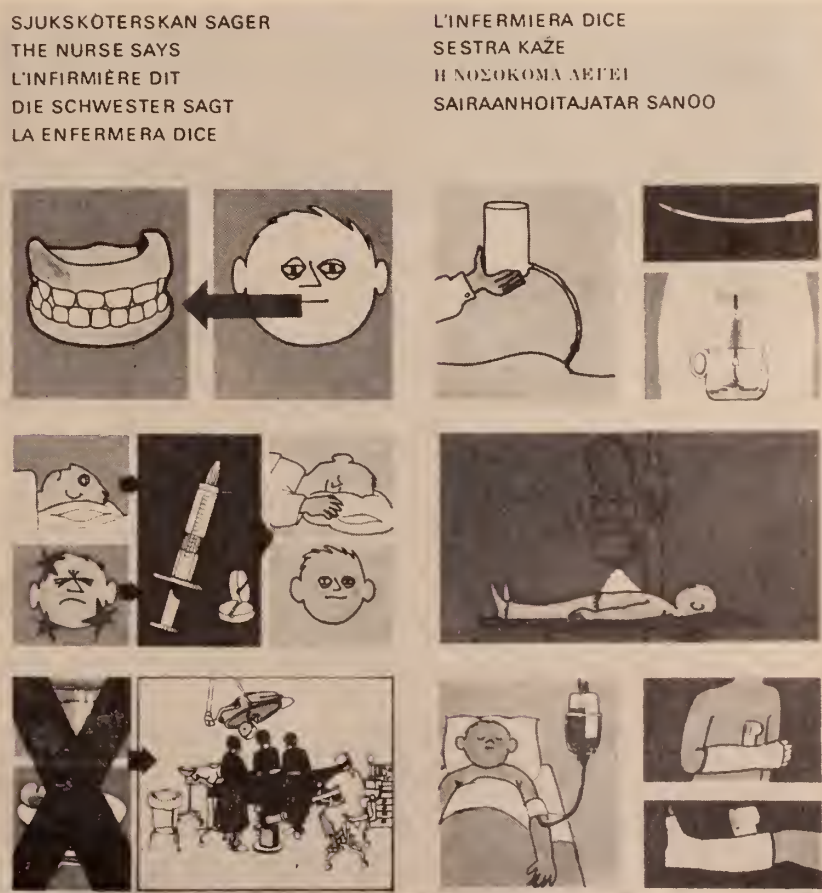


Figure 5

DOKTORN FRÅGAR  
THE DOCTOR ASKS  
LE DOCTEUR QUESTIONNE  
DER ARZT FRAGT  
EL MEDICÒ PREGUNTA

IL DOTTOR SI INFORMA  
DOKTOR PITA  
Ο ΙΑΤΡΟΣ ΠΙΤΑ  
TOHTORI KYSYY



Figure 6

months listed in blue boxes and the months one to nine underneath in a row of red boxes. And a profile of a pregnant woman with a question mark pointing at her abdomen. If she can just read arabic numbers, we can very quickly get a lot of information from this page. Of course, you will examine the patient, too, but you can tell a lot from this and from just looking at her.

*Q:* What about determining the patient's drug sensitivities and so on?

*Adams-Ray:* If a patient has been taking cortisone, and you don't know it and you operate on him, he might die from shock. So we have this on page 40 (Figure 6) to find out what medication he may be taking and to what drugs he may be allergic. We can ask whether he has gotten penicillin or cortisone

and by what route, and whether he may be allergic to either of these.

*Q:* Maybe he can read penicillin and cortisone and maybe he can't.

*Adams-Ray:* But then he can write the name of any such drug by hand, there is space for this and written messages and drawings in the back of the book. The important question we can ask is "Is there any medicine that you can't stand?" Another vital question: "Have you been using insulin?" (page 41) And in the picture underneath, this is the international symbol for epilepsy. Now when the patient comes to you you take his temperature, but it might be important to ask, "Have you been running a fever?" That's why we show a thermometer with a question mark (Figure 6).

Q: And here underneath a comparative chart with Fahrenheit, centigrade, and *what* is "R"?

Adams-Ray: Reaumur. That has 80 degrees in place of the 100 in the centigrade scale. There are some places in the world where they use it, but this Fahrenheit, you are going away from it in America now, and I think you will go over to the metric system altogether soon, as they are doing in Canada. So with these scales we can ask about the fever history and we can quickly show them what their temperature is on the scale they are used to. On the next page (41), if the patient was in a vehicle accident, you may want to know what kind of vehicle, where they were sitting in or on it, or whether they were walking, and so on. Now on these last lined pages (43-44) we show a pencil stub at the top and the patient may use these sides to draw or write on because, of course, we can't show everything. He can cut pictures out of magazines and paste them up for the same purpose.

Q: Professor Adams-Ray, have you had occasion to use your book since it was published, with a patient in a clinical situation?

Adams-Ray: I retired just before it came out (in Sweden) in October 1970. I retired July 1, 1970. But I have kept in touch with the doctors and nurses at my hospital who are very pleased with it. I met a pediatrician last Saturday who uses it with foreign children, to make contact both with the children and their parents. Even youngsters a few years old got the idea fast to "say" what they wanted. And he could use it both for diagnosis and for everyday care of the patient. He gave me some good ideas for some new pictures to meet the special needs of pediatrics. We are working now on a new edition. Professor Alkjaer in Aarhus (Denmark) wrote an enthusiastic article saying the book was an "age of Columbus" when it comes to making contact with the patient. He said all foreign patients and all hospitals should have it. He was very enthusiastic.

Q: But if you had to say what its weaknesses are, what would you say?

Adams-Ray: Well, there are some things that we haven't put in it that might be important. I should say that we have not made it too fat just to keep it pocket-size. But there are some things missing that we plan to include in our next edition. "Has this tumor been growing?" "Has it been growing rapidly?" The doctor's chapter now is pretty much about pain and acute case-oriented. We have no dermatology in it. We will picture a little lump and then we will show it growing. Of course, this was more important in the old days. Today in big hospitals they biopsy the lumps. Now with the pediatric patients, you want to know if the child has been crying a lot or losing appetite. To show appetite loss you have a child eating, smiling on the left hand side, and on the right hand side you show a wonderful dish and the child putting his hands up in refusal. The important thing, as many good responses show, is that there is a real need for this *Interpreter*. I can tell you from personal experience there is. It establishes contact in a situation of need, it closes the gap, it is simply very useful.

The foregoing dialogue is based on an ad-libbed interview, recorded October 29, 1971 in Stockholm, Mr. Garner, who conducted the interview, edited and in parts rewrote the transcript to add details and to smooth the style. Requests for reprints should be addressed to Jack Adams-Ray, M.D., Riddargatan 39, S-114, 57 Stockholm, Sweden. *Pictorial Interpreter of Medicine* is available from Haakan Ohlssons Forlag, Box 1023, S-221, 04 Lund 1, Sweden.

## References

1. Adams-Ray, Jack, M.D., and Folkesson, Claes: *Pictorial Interpreter of Medicine*. Haakan Ohlssons Forlag, Lund, Sweden (1970). Copies may be purchased for \$1.95, plus 25¢ shipping charge (less for quantities) from T. M. Visual Industries, 25 West 43th Street, New York 10036.





**Ampicillin, Carbenicillin, Oxacillin...**

# **IMAGINE YOUR PRACTICE WITHOUT THEM**

In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

Need we say more?

Prescribe the discoverer's brands:

**Totacillin<sup>®</sup>** (ampicillin trihydrate)

**Pyopen<sup>®</sup>** (disodium carbenicillin)

**Bactocill<sup>®</sup>** (sodium oxacillin)

and more to come

**Beecham-Massengill  
Pharmaceuticals **BMP****

Div. of Beecham Inc. Bristol, Tennessee 37620

- ☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.
- ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
- ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.



0.5 Gm tablets  
**ORINASE<sup>®</sup>**  
tolbutamide, Upjohn

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001  
JA72-2407-6  
© 1972 The Upjohn Company





**if skin is infected,  
or open to infection...  
choose the topical  
that gives your patient—**

- ☞ broad antibacterial activity against susceptible skin invaders
- ☞ low allergenic risk—prompt clinical response

**Special Petrolatum Base**  
**Neosporin<sup>®</sup> Ointment**  
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical aftercare, and pyogenic dermatoses.

*Precaution:* As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709





**Pink isn't exactly his color,  
but he loves it for a change.**

## **WinGel<sup>®</sup>**

aluminum-magnesium hydroxides  
mint-flavored antacid liquid and tablets

For your ulcer and ulcer-prone patients...  
a refreshing break from the  
boring sameness of white antacids.

- pleasing mint flavor
- non-gritty texture
- formulated to avoid  
constipation and laxation



**Winthrop**

WINTHROP LABORATORIES  
NEW YORK, N.Y. 10016

# Anatomy of a Doctor.

You know what it takes to make a doctor. The motivation. The years of study and training. The dedication. The hard work.

But from the criticism leveled at doctors lately you'd think neither the public nor press had any idea.

It may surprise you, but the public does.

This was evidenced in a recent Harris Poll. In measuring public respect for U.S. leadership, it showed a drastic drop in the past five years. And "a majority of Americans is currently willing to express a 'great deal of confidence' in only one profession — medicine — on a list covering 16 types of activity." And that list included Congress and the Supreme Court.

People still look at their doctors as men to be respected and as men of integrity.

This is the true story of the American doctor. And one which the AMA is constantly telling the public as part of its communications program.

In newspapers and magazines, the AMA tells what it takes to be a doctor. American medicine's achievements. And to express the profession's concern by providing information to help every American lead a healthier life.

We can be an even more effective spokesman...with your support. Find out more about what the AMA does for you and the public. Send for a free pamphlet. Write: Dept. DW, at the address below.

**JOIN US.  
WE CAN DO MUCH MORE TOGETHER.**

American Medical Association  
535 North Dearborn Street/Chicago, Illinois 60610





---

# NEW JERSEY DOCTORS' NOTEBOOK

---

## Eye Health Screening: Medical Society's Experience\*

The Medical Society of New Jersey is the sponsor of the oldest eye screening program in our state. Started in 1956 by the Commission for the Blind (and now in its 15th year), responsibility for the program was assumed by the Sight Conservation Committee of the Medical Society in 1957. Since then over 130,000 people have been screened through 1971.

The program is conducted each September (Save Your Sight Week) as a public health endeavor. It is an important mechanism for searching out glaucoma—a major detriment to vision and other eye disorders, and is a timely educational project, alerting the public to the need for early medical eye care. Most ophthalmologists volunteer their services through the 86 hospitals which offer their facilities for this vital program.

During the period 1957-1971, a total of 131,118 persons were screened through this program (see Table I). Of these 44 per cent were found to be positive in one or more of the following categories—visual acuity, external inspection, ophthalmoscopy, or tonometry.

The Eye Health Services of the New Jersey Commission for the Blind has assumed responsibility for the follow-up of all glaucoma patients which account for 5 per cent of those showing any deviation from normal. Follow-up reports clearly show that a high proportion of glaucoma suspects are ultimately examined by private ophthalmologists. Examinations at eye clinics of glaucoma suspects showed a decline from 14 per cent in 1968 to 9 per cent in 1970.

The 1970 figures seem worthy of closer review. Of the glaucoma suspects examined, 35 per cent showed a positive diagnosis, while ap-

proximately 5 per cent were diagnosed as either suspicious or borderline. Only 3 to 4 per cent failed either to reply to the follow-up or to arrange for an eye examination. This was despite an intense follow-up program of letters, phone calls, and house visits. Such findings quickly suggest the value of public health service programs as an aid in the prevention of blindness through the early detection of glaucoma suspects and treatment of glaucoma patients as a major force in holding back the curtain of blindness.

### Program Method

Traditionally Eye Health Screening Centers have been set up throughout the state at general or specialty hospitals. At each center a physician is placed in charge of the program. One function of the physician in charge is to assume responsibility for the statistical breakdown of the cards used at the center. An evaluation sheet is also provided for tabulating results at the end of the program (see evaluation sheet).

At the conclusion of the program the physician in charge collects and returns all cards to The Medical Society of New Jersey for tabulation and analysis. The local physician in charge is responsible for designating cases in which follow-up by the Eye Health Service of the New Jersey Commission for the Blind is indicated. All statewide publicity for the program is handled by The Medical Society of New Jersey.

The Eye Health Services Office of the New Jersey State Commission for the Blind at-

---

\*This material has been prepared by Alfonse A. Cinotti, M.D., and Mark A. Quinones, Ph.D. Dr. Cinotti is Chairman of MSNJ's Committee on Conservation of Vision, Hearing, and Speech, and Director and Professor, Division of Ophthalmology, New Jersey Medical School (CMDNJ) at Newark; Dr. Quinones is Director, Division of Social Medicine, and Assistant Dean for Allied Health, New Jersey Medical School (CMDNJ) at Newark.



tempts to reach every suspect reported. Each case is followed until every patient has a complete eye examination. Cooperating agencies are the New Jersey Academy of Ophthalmology and Otolaryngology, New Jersey State Commission for the Blind, State Department of Health, New Jersey Hospital Association, and the Women's Auxiliary to The Medical Society of New Jersey.

### Range of Tests

Tests incorporated in the program have included visual acuity, external inspection, ophthalmoscopy, and tonometry. In most of the centers nurses sponsored by the Women's Auxiliary conduct the visual acuity tests. Physician services are used in conducting the tonometry and ophthalmoscopy. Referral of cases is left to the discretion of the examining physician rather than based on a specific scale reading. This allows for consideration of family history, appearance of optic discs, differences in reading between the two eyes, age, and cooperativeness of patient.

Almost half of the population tested over the past 15 years have shown some ocular defect. The greatest number of positive subjects has decreased visual acuity. Our standard is 20/30 (or less) as tested with the Snellen chart at 20 feet. If near vision testing were

also included, it is likely that the proportion of visual defects would be greater. Since this figure is much higher than all other categories, the assumption can be made that a good proportion of these defects represents refractive errors (approximately 30 per cent.).

### Findings

Table I provides an analysis of the results of the Medical Society eye screening program from inception to present. The number screened during 1971 tripled over the number screened during the initial year (1957); yet the number of positives was more than five times greater during 1971 than was the case in 1957.

The program seems to have reached its optimum potential for screening in 1964 (the approximate mid-year of the program), with a surprisingly lower screening level during 1966. Since then the number screened has remained rather constant. A closer examination of the data enables certain predictions. There were 58,965 positives, most of which (approximately 38,000) were refractive errors. Tonometry uncovered 6,846 suspects; one third of these were actually diagnosed as glaucoma. The program has picked up approximately 2,000 glaucoma patients.

TABLE I  
*Eye Health Screening Programs (MSNJ)*  
1957-1971

Year	Total Screened	Total Positive	Visual Acuity†	External Inspect.†	Ophthalmoscopy†	Tonometry
1957	4,062	956			888	260
1958	5,627	2,416				328
1959	4,784	2,392				298
1960	5,496	2,669				362
1961	7,426	3,431	2,939	530	888	405
1962	7,758	3,875	3,324	433	870	529
1963	8,157	3,755	3,188	382	851	467
1964	12,892	5,784	4,820	546	1,149	684
1965	10,899	4,856	4,250	356	936	532
1966	7,402	3,526	3,021	322	738	404
1967	10,620	4,674	4,012	387	1,085	576
1968	11,659	5,243	4,536	474	1,041	561
1969	11,114	5,175	4,532	468	1,167	464
1970	10,986	4,901	3,806	363	843	456
1971	12,236	5,223	4,613	304	869	504
Total	131,118	58,876	38,509	4,565	10,437	6,830

†Statistical breakdown of those screened positive not available from 1957-60. Complete analysis made from 1961 through current program.

From past experiences we expect to find that about half of those screened will have positive findings. It also seems clear that there is a consistency in regard to tonometry findings which seem to account for from 4 to 5 per cent of the total screened. The ratio of glaucoma suspects throughout the state varied from a low of 5 per cent in 1950 to a high of 5.1 per cent in 1971. These figures are high when compared with the reported national average of approximately 2 per cent of all persons over age 40 who have glaucoma.

Several explanations are offered for the high proportion of glaucoma suspects. Most important is the necessary caution taken by the ophthalmologist when borderline tensions are recorded. Borderline tensions usually require further tonometry, visual field studies and possibly provocative tests and tonography before the diagnosis can be established. In addition, there is a tendency on the part of many people with glaucoma to seek another opinion. Other false positive results may be due to squeezing on the part of apprehensive patients and in some cases the taking of tensions by interns.

External inspection of the eye and adnexa revealed 3.4 per cent of total: extra-ocular muscle imbalance, lid and conjunctival infections, pterigia, and various corneal diseases.

Ophthalmoscopically visual conditions were found in 10,437 or 7.9 per cent of those screened. These included such diseases as cataracts, vitreous changes, optic nerve, and various types of retinopathy.

Depending on the severity of the condition, patients were advised to seek eye care either at a clinic or private ophthalmologist. However, no attempt was made to follow-up this group.

Medical School Program

To make the Medical Society's program an ongoing activity, the Society approved the establishment of a mobile unit which was funded by the United States Public Health Service

and sponsored by the College of Medicine and Dentistry of New Jersey—New Jersey Medical School in June, 1967. The purpose was to:

- (1) make the screenings available throughout the year in a variety of settings,
- (2) reach an optimum number of people,
- (3) provide eye care in areas of greatest need,
- (4) disseminate information on eye care so as to alert the public to the preventability of much blindness,
- (5) aid the college residency program by providing a case-finding system.
- (6) make available referrals to our affiliated hospitals.

Initially, the unit team was manned by an ophthalmologist, a nurse, and a technician, with back-up from the faculty and residents of the medical school and affiliated hospitals. Arrangements for screening were made directly through the division of ophthalmology, or through the eye screening chairman of the Lions Clubs. A special kit was devised containing all the necessary information on this program.

Table II shows the results of the first three years of the mobile unit program. A total of 41,016 patients were screened. Of these 37 per cent were positive. This proportion is lower than that of the Medical Society's program, probably explained by the fact that it is possible to spend more time with patients in the units and consequently the residents are in a better position to make a more definite diagnosis before classifying a patient as a "suspect."

TABLE II  
New Jersey Medical School Eye Health  
Screening Program

Total Screened	41,016	
Total Positive	15,061	37%
Visual Acuity	12,349	30%
External Inspection	31,34	8%
Tonometry	540	1.3%
Ophthalmoscopy	5625	13%

At present, efforts are being made to evaluate various types of settings for screenings. For instance, there are senior citizen groups, institutional groups, industrial groups, model city

groups, as well as public screenings. As might be expected, the senior citizen groups produce the highest number of positives, running 59 per cent (Table III). Interestingly enough, model city programs are also rather high with 36 per cent. In the glaucoma suspects group, we see that there are 3 per cent in the senior citizen group, as we might expect.

ogy, chest x-ray, test for hypertension, cardiac and pulmonary disorders, and, finally, Papanicolaou smears for malignancies. Since the units were not large enough for this program, examining posts were set up at various sites (schools, churches, and so on), preceded by adequate publicity. The most convenient time was found to be between four and eight p.m.

TABLE III  
New Jersey Medical School Eye Health Screening Program  
January 1967-October 1971

	# Screened	# Positive	# V.A.	Ext.	Insp.	Ton.	Ophth.
Senior Citizens	4573	2516 (59%)	2371 (52%)	685 (15%)	134 (2.9%)	1781 (39%)	
Public	20808	7915 (38%)	6422 (30%)	1659 (8%)	297 (1.4%)	2911 (1.4%)	
Institution	2079	520 (20%)	432 (20%)	.94 (4%)	12 (.5%)	101 (5%)	
Industry	8727	2227 (25%)	1675 (19%)	494 (6%)	55 (.7%)	389 (65%)	
Model Cities	4829	1683 (36%)	1449 (30%)	232 (6%)	42 (.9%)	443 (9%)	
Totals	41016	15061 (37%)	12349 (30%)	3134 (8%)	540 (1.3%)	5625 (14%)	

Questions have been raised on the merits of using a mobile unit in large urban areas where physicians could possibly do much more and examine many more patients if they were able to move equipment into the local areas, such as school or church basements. Some feel that this gives more mobility, involves more volunteers, and ultimately screens many more people. Multiphasic programs see 200 people a day, whereas a mobile unit sees about a hundred a day, if refractions are eliminated from the screening. By selectively choosing the audience we can increase our rates in the mobile unit.

### Multiphasic Screening

The third screening program developed was a multiphasic screening program in Newark. This type of screening is a practical method for the early detection of diseases and disorders among a supposedly healthy population. A major advantage lies in the considerable financial savings to the participants and the time saved to the physician.

As a result of participation by the Newark Health Department in the mobile screening program, and its apparent success in reaching large numbers of persons (not otherwise receiving much medical care), it was decided first to conduct diabetic screening along with the eye tests. Later the program included serol-

Table IV shows the results of a two year program in which 11,268 people were screened. From that group, 38.4 per cent were found positive in one or more categories. Four per cent of the total were diabetic suspects. From chest x-rays, 1.5 per cent were found to have abnormal chest conditions, and 1.6 per cent had abnormal cardiac findings. Positive serology appeared in 2.9 per cent. Eight per cent had positive hypertension and one per cent was referred for further examination because of suspicious findings in heart and lungs.

TABLE IV  
Multiphasic Screening Program—City of Newark

Total Patients Screened	11,268
Per cent Referred	38.4
Percentage Referred by Conditions	
1) Diabetics	4
2) Chest X-Rays	
Abnormal Chest	1.5
Abnormal Cardiac	1.6
3) Serology	2.9
4) Hypertension	8.0
5) Heart and Lung	
(By Physical Exam.)	1.0
6) Eye	14

Patients found positive in any of these categories were advised to seek further care either from their own physicians or through the special clinics. Those with abnormal x-rays or other lung pathology were referred to the Chest Disease Bureau. Patients with hypertension, heart pathology, or abnormal cardiac x-rays were referred to the Department of



Health. Those with positive serology were referred to the Venereal Disease Clinic, and those with elevated blood sugars to the Diabetic Clinic. All positive eye cases (14 per cent) were referred to their own ophthalmologist or to the Medical School Eye Clinic. The Health Department communicated with all positive cases, either by letter or home visits, to insure follow-up. When the program records were reviewed, we found it almost impossible to get statistics on the follow-up despite the fact that volumes of papers were produced, showing that these people had been seen. However, no one had recorded the statistics or correlated them. There was no doubt that almost all positive cases in any of the categories were reached by the Health Department which was carrying out a good program yet could not substantiate it with adequate statistics.

### **New Jersey Commission for the Blind and Visually Impaired**

The fourth program is that conducted by the New Jersey Commission for the Blind and Visually Impaired. Through its Eye Health Service division, it provides a program of eye examinations as a service to the community by means of its mobile eye health unit. This unit served the New Jersey schools for twenty-two years. The unit gave complete eye examinations in many school systems throughout the state. In the past few years, the program has been redirected to meet the eye needs of the elderly, the handicapped, and the disadvantaged. Every effort is made to seek out individuals for whom eye care is presently unavailable or available only on a limited basis. Areas remote from eye care facilities are also served.

Beginning in April, 1968, the program provided complete diagnostic eye examinations to nursing homes, senior citizen groups, areas of urban and rural poverty, rehabilitation centers for the handicapped and migrant workers. Other suitable locations were also sought. Follow-up is usually conducted by the professional staff of the cooperating agencies. Those having serious limitations of sight are referred to the New Jersey Commission for

the Blind. Anyone needing treatment, guidance or financial assistance is referred to the Eye Health Service of the Commission. This mobile unit has provided approximately 105,000 diagnostic eye examinations to 99,000 individuals since its inception in 1946.

### **Conclusion**

Almost 288,000 eye screening tests have been performed by ophthalmologists in New Jersey in its various programs. Almost 50 per cent of these (over 131,000) have been conducted under the auspices of the New Jersey Medical School (CMDNJ). These programs have reached all segments of society and have been important in finding eye diseases and thus preventing blindness. Criticisms have been made concerning programs of this type claiming under or over-referrals because of failure to do other tests, i.e., dilation of the pupils, or visual fields. Obviously the ideal would be to have complete examinations on all persons, either yearly or every two years. Such examination would be thorough and would undoubtedly produce a higher incidence of disease than screening programs. However, the cost would be difficult to justify, both financially and in time.

On the positive side, the four parameters used in screening serve as additional safeguards against the chance of missed pathology. For example, decreased vision is cause for referral and generally accompanies eye disease. The presence of a large cup on the optic disc or a familial history of glaucoma with borderline intraocular pressure is also sufficient reason for referral.

As previously mentioned, the referral rate for glaucoma suspects in the Medical Society's annual screening program is about 5 per cent as compared to 1.3 per cent in the Medical School's unit. This obviously is due to the additional time spent testing.

Another factor is the lack of unanimity of medical opinion as to what constitutes glaucoma, and therefore, which patients require treatment. The treating ophthalmologist must

finally decide on the presence of disease and the appropriate treatment. Therefore, the program is deemed successful as long as it is referring potential glaucomas.

The educational merits of these programs are especially important. While some critics decry the fear produced in some patients by being referred, the opposite seems to be the case. People tend to gain a better understanding of eye diseases and learn that glaucoma is not fatal, is treatable, and is quite common.

A vital function of this program is the referral of indigent patients to the clinics of the affili-

ated hospitals. This is also an aid in the medical education of eye residents. More and more patients are now covered by "third party" programs, and they are not going to clinics as they used to.

In summary, a presentation of four types of programs conducted in the State of New Jersey represent alternative ways for providing much needed eye health screening among a heterogeneous population. The mere fact that from 30 per cent to 40 per cent of eye conditions are discovered through these programs is evidence of the value and reflects the needs of the public.

# Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during August 1972:

	1972 August	1971 August
Aseptic meningitis . . . . .	59	48
Primary encephalitis . . . . .	6	2
Post infectious encephalitis . . . . .	0	0
Hepatitis: Total . . . . .	358	364
Infectious . . . . .	289	281
Serum . . . . .	69	83
Malaria: Total . . . . .	2	5
Military . . . . .	0	2
Civilian . . . . .	2	3
Meningococcal meningitis . . . . .	0	2
German measles . . . . .	3	2
Measles . . . . .	0	22
Mumps . . . . .	8	19
Salmonella . . . . .	94	149
Shigella . . . . .	21	36

## Aseptic Meningitis

Aseptic meningitis caused by Coxsackie B5 has been a problem over the eastern United

States this summer. Most of the people affected by the disease have been children and a large number of cases have occurred in infants. In one outbreak, in Washington, D.C., about half of the infants were six months of age or younger.

The same kind of pattern was seen in New Jersey. There have been three small outbreaks of aseptic meningitis affecting mostly children less than six months of age. Coxsackie B5 has been isolated from several of these infants. Fortunately, most had a rather mild clinical illness.

The attack rate for Coxsackie B5 infection is probably the same in all age groups, but the infection probably causes few, if any, symptoms in older children and adults. Coxsackie B5 can cause severe disease in newborns such as encephalitis and myocarditis. In areas where aseptic meningitis is occurring, precautions should be exercised to exclude from work all personnel in obstetrical units or newborn nurseries who are ill with even slight symptoms.

## Medical College Notes

Stanley S. Bergen, Jr., M.D.  
President, CMDNJ

Experience has shown that many disadvantaged students require a great deal of individual tutoring if they are to be successful in medical and dental schools. We refer to disadvantaged students as those who seem to have the intellectual abilities (by all usual measures of achievement) but have been disadvantaged educationally. Because tutorial resources at many schools are limited, attrition among this group is higher than among other students.

This factor often cancels the value of intensive efforts on the part of medical and dental schools to recruit promising, disadvantaged students. It is useless to find, recruit, and matriculate such talented, well motivated students only to see them drop out because of lack of learning skills and inadequate tutorial assistance.

In an effort to begin to solve this problem at our two medical schools—Rutgers Medical School, Piscataway, and New Jersey Medical School, Newark—we have inaugurated programs to assist qualified students in adjusting to the intense performance-oriented life in medical school and to the standards of academic excellence expected of every student. This past summer 66 students participated in the programs—14 at the Rutgers Medical School and 52 at New Jersey Medical School. The entire Rutgers group will be in the freshman class this fall. At New Jersey Medical School in Newark, 18 are in the class of 1976. The balance of the students participating in the Newark program are college students who are seriously considering seeking careers in medicine and dentistry in the future.

The work-study programs conducted at both schools during this past summer stressed intensive academic training and orientation for these students. During the program, the students had an opportunity to work in research and diagnostic laboratories at the college hospitals. There was also a formal program of

instruction in pre-medical sciences and in the development of learning skills. An important element of the summer programs is the opportunity to meet and get to know medical students, faculty, and physicians.

Both programs were supported by external financial assistance. The Commonwealth Fund provided \$15,000 while \$55,000 came from the Robert Wood Johnson Foundation to help defray stipend costs. An HEW grant of \$87,709 was provided to assist in the overall support of the ongoing operational costs of the Rutgers Medical School program and a \$158,000 HEW grant has been applied to similar needs at the New Jersey Medical School. We are indeed grateful for the grants we have received from both the public and private sector. The commitment of our faculty and administration to equal educational opportunity is greatly enhanced by this support.

The end of summer did not mean the end of the program. Throughout the year students at the Rutgers and Newark schools will be counseled, their progress analyzed, and individual and small group tutorial instruction provided when and where needed. Of added importance is an ongoing research and evaluation program to help us gain greater insight into the problems of student needs in general as well as those of the disadvantaged.

Due to the efforts of Mr. Foster Burnett, director of the New Jersey Medical School program, the program has attracted national notice. The Educational Research Center of the Massachusetts Institute of Technology has asked for consultation in setting up similar programs overseas for students in European and South American medical schools.

The College faculty and administration has grown increasingly aware that student motivation and dedication may not be enough to assure success in medical school. We must strive to compensate for both the social factors and unequal opportunities which have previously limited many students' chances of success in seeking careers in medicine.



# PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.*

**ANESTHESIOLOGY**—Celia Mencado Sagullo, M.D., 138 Terrace Place, Brooklyn, New York 11218. Manila 1963. Board eligible. Group or partnership. Available.

**CARDIOLOGY**—Paul Goldfinger, M.D., U.S. Navy Hospital, Department of Cardiology, Portsmouth, Virginia 23708. George Washington, 1966. Board certified (IM), Board eligible (C). Group, partnership, hospital. Available July 1973.

Richard H. Landesman, M.D., 477 Comstock Place, Highland Park, Illinois 60035. Vermont 1966. Board certified (IM). Group, partnership, hospital. Available July 1973.

**DERMATOLOGY**—Robert P. Feinstein, M.D., 9146 Springhill Lane, Greenbelt, Maryland 20770. NYU 1967. Board eligible. Group, partnership, solo. Available July 1973.

**FAMILY PRACTICE**—Biagio Scialpi, M.D., 156 Caryl Avenue, Yonkers, New York 10705. Bari (Italy) 1949. Group, associate, solo. Available.

**GASTROENTEROLOGY**—Kambiz Azmudeh, M.D. 6255 Broadway, Bronx, New York 10571. Tehran 1964. Board eligible. Group, or partnership. Available.

Ernest T. Bajpai, M.D., 250 Beverly Boulevard, Apt. F-105, Upper Darby, Pennsylvania 19082. Prince of Wales (India) 1955. Board eligible. Group or full-time salaried. Available July 1973.

Eugene F. Cheslock, M.D., 107 Beverwyck Drive, Guilderland, New York 12084. New Jersey Medical 1965. Subspecialty hematology. Board eligible. Group or hospital.

Cesar Soriano, Jr., M.D., 320 East Chestnut Street, Coatesville, Pennsylvania 19320. Santo Tomas (Philippines) 1965. Board eligible. Group, associate, partnership. Available.

**INTERNAL MEDICINE**—Noorollah Kashani, M.D., 546-B Main Street, Hackensack 07601. Tehran 1966. Board eligible. Subspecialty gastroenterology. Association or partnership. Available.

**OBSTETRICS-GYNECOLOGY**—Charles J. Seigel, M.D., 217-10 Lexington Boulevard, Clark, New Jersey 07066. Pittsburgh 1967. Board eligible. Group or partnership. Available July 1973.

Jae-hak Choe, M.D., 481 8th Avenue, New York 10001. Kwangju (Korea) 1965. Board eligible. Associate, group, or partnership. Available July 1973.

**ORTHOPEDICS**—Rother A. Bronfman, M.D., 8702 Pennsbury Place, Apt. 2, Richmond, Virginia 23229. New Jersey Medical 1966. Board eligible. Solo, partnership, group. Available July 1973.

Frank G. Guellich, M.D., Valley Forge Army Hospital, Phoenixville, Pennsylvania 19460. New Jersey Medical 1966. Board eligible. Solo or partnership (Mercer, Morris, or Somerset Counties). Available July 1973.

T. K. Kobayashi, M.D., 812 Woodside Drive, Iowa City, Iowa 52240. Colorado 1966. Board eligible. Group or partnership. Available July 1973.

**OTOLARYNGOLOGY**—George W. Hicks, M.D., 6139 Broadmoor Plaza, Indianapolis, Indiana 46208. St. Louis 1967. Board eligible. Group, partnership, association. Available July 1973.

Gary L. Townsend, M.D., 117 Nebraska Street, Dyess AFB, Abilene, Texas 79607. Yale 1966. Board certified. Solo. Available July 1973.

**PATHOLOGY**—E. Clifford Heinmiller, M.D., 1124 Washburn Place West, Saginaw, Michigan 48602. Iowa 1943. Board certified, AP and CP. Subspecialty computer science. Group for development of medical computer applications, medical records, diagnosis, etc. Available.

**PEDIATRICS**—N. Boramanand, M.D., 331 East 29th Street, Apt. 14-P, New York, New York 10016. Birmingham (England) 1965. Subspecialty, pediatric neurology. Board certified. Group, partnership, association. Available July 1973.

Barton W. Kaplan, M.D., P.O. Box 741, 4108 Hyde Park Drive, Chester, Virginia 23831. Upstate Medical Center (Syracuse) 1968. Special interest, developmental problems. Board eligible. Group, partnership, or association. Available July 1973.

J. S. Bharara, M.D., Monmouth Medical Center, Long Branch 07740. Amritsar (India) 1961. Board eligible. Group or partnership. Available.

**SURGERY**—Michael J. Attkiss, M.D., 23 Hemlock Road, Newton, Massachusetts 01264. Columbia 1964. Group, partnership, solo, hospital, teaching. Available July 1973.

Nestor M. Sagullo, M.D., 138 Terrace Place, Brooklyn, New York 11218. Manila 1963. Board eligible. Solo or partnership. Available.

**UROLOGY**—Eugene J. Lind, M.D., 4B Collins Street, Westover Air Force Base, Massachusetts 01022. NYU 1966. Board eligible. Partnership or group. Available August 1973.

Franklin A. Morrow, M.D., 1 Wall Street, Fort Lee, New Jersey 07024. New York Medical 1966. Board eligible. Association or solo.

Bashiduddin N. Shaikh, Lockwood Clinic, 300 Bloor Street East, Toronto, Ontario, Canada. B. J. Medical (India) 1961. Board eligible. Group, partnership, solo. Available.

Marvin S. Wetter, M.D., 70-35 260th Street, Glen Oaks, New York 11004. Jefferson 1966. Group or partnership. Available July 1973.

J. G. Besai, M.D., 52 East Maple Street, Teaneck 07666. Bombay (India) 1958. Board eligible. Solo or association. Available.

---

# ANNOUNCEMENTS

---

## Clinical Application of Basic Sciences

The October and November programs for the Burlington County Memorial Hospital's series on the clinical application of the basic sciences have been listed as follows.

October 5	Heart Failure in the Elderly
October 12	Emotional Problems of Hospitalized Patients
October 19	Aggression and Violence
October 26	The Battered Child
November 2	Community Mental Health Problems
November 9	New FDA Regulations
November 16	Diet Therapy—Fact or Fallacy
November 30	Iatrogenic Neurological Disorders

All lectures are presented at the T. J. Summey Building across from the hospital and the meetings convene promptly at 3:30 p.m. The American Academy of Family Practice gives one and a half credits per session. Further information may be obtained from the Department of Medical Education at the hospital (175 Madison Avenue, Mount Holly).

## Biologic Feedbacks in Medicine

On Tuesday, October 17th at 8:30 p.m., St. Joseph's Hospital in Paterson will hold a discussion on biofeedback in psychosomatic medicine. Speaker will be Charles F. Stroebel, Ph.D., of Hartford, Connecticut. Moderator will be Gerhard R. Hirschfield, M.D., Chief of Psychiatry at St. Joseph's. The seminar is scheduled for room GO-35 at the hospital at 703 Main Street.

## Radiologic Seminars

The Department of Radiology of Rutgers Medical School, CMDNJ, announces the following three programs in its series of seminars in radiology, to be held the third Wednesday of each month, October through May. Additional programs will be listed next month.

October 18	Radioimmunoassays Bernard Shapiro, M.D. Albert Einstein Medical Center
November 15	Gastrointestinal Tract Ralph Schlaeger, M.D. Columbia-Presbyterian Medical Center

December 13    Benign Bone Tumors  
Meyer Alpert, M.D.  
Franklin General Hospital

Meetings convene promptly at 5 p.m. in the Basic Science Building, Link Room 203, Rutgers Medical School, New Brunswick. There is no fee. Further information may be obtained from the Acting Chairman of the Department of Radiology, Charles P. diLiberti, M.D., at the Raritan Valley Hospital, 275 Greenbrook Road, Green Brook 08821.

## Symposium on Emergency Treatment

On Saturday, October 28, at the Holiday Inn in Saddlebrook, there will be an all-day symposium (9 a.m. to 5 p.m.) on "Emergency Patient Treatment." The program is presented by the Pascack Valley Hospital in Westwood, and topics offered cover multiple injuries, cardiac crises, acute psychiatric emergencies, and drug abuse. The American Academy of Family Practice has given approval for eight hours' credit. Registration fee is \$25 and includes a coffee break and luncheon. For further information and advance registration, please communicate with Stewart F. Alexander, M.D., Pascack Valley Hospital, Westwood 07675, or telephone (201) 664-4000.

## Session on EENT

The New Jersey Academy of Ophthalmology and Otolaryngology will hold its annual meeting on November 8 at the Robert Treat Hotel in Newark. The ophthalmology section has scheduled two symposia: one on glaucoma in the morning and an afternoon session on cataracts. The otolaryngology program will cover such subjects as cryosurgery in otology, noise pollution, nasomaxillary ostium insufficiency, neoplasms in the aerodigestive tract, and aberrant thyroid gland. Luncheon will be served at 12:30 p.m. and a business meeting will convene at 5 o'clock, followed by a reception and buffet. There is a \$20 registration fee for non-members. For reservations,

write to the Executive Secretary of the Academy, Mr. Marshall Klein, Eye Institute, 15 South Ninth Street, Newark 07107.

### **Seminar in Arthrography**

On Wednesday, November 8, the Rutgers Medical School, New Brunswick, will conduct a radiologic seminar in arthrography. The program, which is held in the main auditorium of the Basic Science Building, will start promptly at 2 p.m. and run until 5 p.m. Moderators are Charles P. diLiberti, M.D., Acting Chairman of the Department of Radiology, and Joseph P. Zawadsky, M.D., Chief of the Division of Orthopedic Surgery. Subjects to be covered are technics of knee and shoulder arthrography and surgical management of shoulder lesions. An outstanding faculty has been selected. For further information, please write to Charles P. diLiberti, M.D., Raritan Valley Hospital, Green Brook 08812.

### **Interstate Scientific Assembly**

An assembly of the Interstate Postgraduate Medical Association will be held at the Washington-Hilton, Washington, D.C., November 13 through 16. Primarily designed for family physicians and internists, this is an educational service providing a diversified lecture program, live television, medical motion pictures, and panel discussions. Special symposia on diabetes, pediatric problems in office practice, urinary infections, hypertension, and anemia are included in the program. Faculty members of George Washington, Georgetown, and Howard Medical Schools provide major portions of the instruction.

The meeting is open to any licensed MD in the United States or Canada. Fee is \$25 for 26 hours of instruction, which provides credit for members of the American Academy of Family Practice. For further details write to Alton Ochsner, M.D., P.O. Box 5445, Madison, Wisconsin 53705.

### **A Course on the Knee**

A graduate medical course on disorders of the knee will be offered by the Division of Or-

thopedic Surgery at the New Jersey Medical School, CMDNJ, on Friday and Saturday, November 17 and 18, at the Downtowner Hotel in Newark. This is cosponsored by the Academy of Medicine of New Jersey. Participants will receive 18 hours of continuing education credit. The program has American Medical Association accreditation by virtue of the Academy's cosponsorship.

Subjects to be covered on Friday include anatomy of the quadriceps apparatus, biomechanics of the knee, recurrent dislocation of the patella, chondromalacia, transposition of the patellar insertion, femoral arthritis, "save the patella," and muscle weakness and joint stiffness. Topics for Saturday will be anatomy of the ligaments of the knee, evaluation of acute injuries of the knee, anterior cruciate lesions, evaluation of internal derangements, meniscus lesions, arthrograms, and rehabilitation of the knee.

A fee of \$100 will cover tuition, luncheons, coffee breaks, and a dinner on the evening of November 17.

### **Rheumatism Meeting in Pittsburgh**

The Arthritis Foundation announces a scientific assembly of its rheumatism section at the Hilton Hotel in Pittsburgh on December 8-9, 1972. The program includes graduate seminars on arthritis, a session on collagen diseases, and a seminar on mucopolysaccharidoses. For details write to the Executive Secretary, Arthritis Foundation, 1212 Avenue of the Americas, New York, New York 10036.

### **Seaboard Seminar in February**

The Warren County Medical Society is sponsoring a medical seminar at sea, aboard the *S. S. France*, February 2 to 9, 1973. The cruise to the Caribbean will include stops at St. Thomas and St. Maarten. For details, please write to Arthur A. Altman, M.D., Department of Pathology, Warren Hospital, Phillipsburg, New Jersey 08865.



# MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1972

October

- |   |   |
|---|---|
| <p>10 Academy of Medicine of New Jersey<br/>Paul Kimball Hospital, Lakewood<br/>Renal Failure</p> <p>11 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Retinal Diseases</p> <p>11 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Gastric Lesions</p> <p>12 Burlington County Memorial Hospital<br/>Mount Holly<br/>Emotional Problems of Hospitalized Patients</p> <p>16 CMDNJ (Newark)<br/>Martland Hospital, Newark<br/>Soft Part Sarcomas</p> <p>18 Academy of Medicine of New Jersey<br/>Atlantic City Hospital<br/>Atlantic City<br/>Hypertension</p> <p>18 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Minimal Breast Cancer</p> <p>18 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Psychiatry-Oriented Interviews in<br/>General Practice</p> | <p>19 Burlington County Memorial Hospital<br/>Mount Holly<br/>Aggression and Violence</p> <p>21 Associated Eye Residencies of New<br/>Jersey and Eye Institute of New Jersey<br/>Eye Institute, Newark<br/>Mononuclear Exophthalmos</p> <p>24 Academy of Medicine of New Jersey<br/>Overlook Hospital, Summit<br/>Medical Care in the Emergency Room</p> <p>25 Academy of Medicine of New Jersey<br/>and New Jersey Allergy Society<br/>Holy Name Hospital, Teaneck<br/>Pediatric Allergy</p> <p>25 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Adrenal Disease</p> <p>25 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Medical-Surgical Cardiology Conference</p> <p>26 Academy of Medicine of New Jersey<br/>and Radiological Society of New Jersey<br/>Hospital Center at Orange<br/>Interesting x-rays of the Month</p> <p>26 Burlington County Memorial Hospital<br/>Mount Holly<br/>The Battered Child</p> <p>28 Academy of Medicine of New Jersey<br/>St. Barnabas Medical Center<br/>Livingston<br/>Anemias</p> |
|---|---|

## November

- |  |  |
|--|--|
| <p>1 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Newark Beth Israel Medical Center<br/>St. Michael's Medical Center<br/>Newark<br/>Diseases of the Adrenals</p> <p>1 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Genetic Disease</p> <p>1 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Drugs in Treatment of Hypertension</p> <p>2 Burlington County Memorial Hospital<br/>Mount Holly<br/>Community Mental Health Problems</p> <p>6 CMDNJ (Newark)<br/>Martland Hospital, Newark<br/>Splenectomy for Hematologic Disorder</p> <p>8 Academy of Medicine of New Jersey<br/>Holy Name Hospital, Teaneck<br/>Marantology</p> <p>8 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Newark Beth Israel Medical Center<br/>St. Michael's Medical Center<br/>Newark<br/>Thyroid Physiology and Abnormalities</p> <p>8 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Neurophysiology and Behavior</p> <p>8 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Nephrotic Syndrome</p> | <p>8 New Jersey Academy of Ophthalmology<br/>and Otolaryngology<br/>Robert Treat Hotel, Newark<br/>Annual Fall Meeting</p> <p>9 Burlington County Memorial Hospital<br/>Mount Holly<br/>FDA Regulations and Medical Practice</p> <p>14 Academy of Medicine of New Jersey<br/>Paul Kimball Hospital, Lakewood<br/>Hypertension</p> <p>14 Academy of Medicine of New Jersey<br/>Bloomfield<br/>Palmar and Plantar Dermatoses</p> <p>14 Academy of Medicine of New Jersey<br/>Morristown Memorial Hospital<br/>Morristown<br/>Treatment of Prostatic Cancer</p> <p>15 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Newark Beth Israel Medical Center<br/>St. Michael's Medical Center<br/>Newark<br/>Parathyroids and Calcium Metabolism</p> <p>15 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Pacemakers</p> <p>15 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Anginal Pain</p> <p>16 Burlington County Memorial Hospital<br/>Mount Holly<br/>Diet Therapy—Fact or Fallacy</p> <p>17 Academy of Medicine of New Jersey<br/>and New Jersey Medical School<br/>(CMDNJ)<br/>100 Bergen Street, Newark<br/>Symposium on the Knee</p> |
|--|--|

- |  |   |
|--|---|
| <p>21 Academy of Medicine of New Jersey<br/>Overlook Hospital, Summit<br/>Proper Use of Antibiotics</p> <p>22 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Newark Beth Israel Medical Center<br/>St. Michael's Medical Center<br/>Newark<br/>Disorders of the Pituitary and Hypothalamus</p> <p>22 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>New Concepts in Antibiotics</p> <p>22 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Management of Tuberculosis</p> <p>28 Academy of Medicine of New Jersey<br/>Hoffmann-LaRoche Auditorium<br/>Nutley<br/>The Weed System</p> <p>29 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Newark Beth Israel Medical Center<br/>St. Michael's Medical Center<br/>Newark<br/>Normal and Abnormal Gonadal Function</p> <p>29 Academy of Medicine of New Jersey,<br/>Academy of Family Practice, and<br/>Clara Maass Memorial Hospital<br/>Clara Maass Memorial Hospital<br/>Belleville<br/>Problems with Commonly-Used Hospital<br/>Drugs</p> <p>29 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital</p> | <p>Bergen Pines County Hospital<br/>Paramus<br/>Diseases of the Parathyroid</p> <p>30 Academy of Medicine of New Jersey<br/>and Radiological Society of New Jersey<br/>Hospital Center at Orange<br/>Interesting x-rays of the Month</p> <p>30 Burlington County Memorial Hospital<br/>Mount Holly<br/>Iatrogenic Neurological Disorders</p> <p><b>December</b></p> <p>6 Academy of Medicine of New Jersey<br/>Hoffmann-LaRoche Auditorium<br/>Nutley<br/>Application of Laboratory Tests</p> <p>6 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Application of Serum Enzymes</p> <p>7 Academy of Medicine of New Jersey<br/>Martland Hospital, Newark<br/>Non-Medical Use of Drugs</p> <p>7 Burlington County Memorial Hospital<br/>Mount Holly<br/>Thrombophlebitis and Thromboembolic<br/>Diseases</p> <p>13 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Cardiomyopathies</p> <p>14 Burlington County Memorial Hospital<br/>Mount Holly<br/>Anticoagulant Therapy</p> <p>20 Bergen Pines County Hospital<br/>Paramus<br/>CPC Meeting</p> |
|--|---|



---

# LETTERS TO THE JOURNAL

---

## Warts Are Treatable

August 3, 1972

Dear Mr. Editor:

Until now the treatment of warts has been very unsatisfactory. Warts are circumscribed, benign, virus-induced, epithelial growths of the skin and adjoining membrane. The virus does not grow in the skin or cornea of laboratory animals or in tissues of the chick embryo. It may grow in tissue cultures of monkey kidney or embryonic human or mouse skin. Experimental inoculation of ground, filtered wart tissue into human skin results in development of warts at the sites of injection in a few weeks to a few months.

Viral particles are 45 to 75  $\mu$  in size and roughly spherical. They tend to be closely packed in a crystalline arrangement. One virus (or closely related strain) appears to cause several different morphologic types of warts depending upon local tissue differences and varied host reactions. The principal pathologic condition is in the epidermis, where there is varying hyperplasia of the prickle cell, granular or horny layers depending upon the type and location of the wart. Characteristic large, vacuolated cells without intercellular bridges appear in the upper prickle cell and granular layers. The nuclei of these cells presumably contain virus inclusions.

Warts are common; their distribution is world-wide; they affect both sexes at all ages. There is a peak incidence between 10 and 20 years. Warts are auto-inoculable, as demonstrated by kissing lesions, satellites, and new lesions along scratch lines passed through older warts. The disorder is contagious, but the source and method of infection are frequently unknown. Minor breaks in the epithelium may be important in establishing the infection.

Warts occur anywhere on the skin or mucous membrane adjacent to the skin. They may be single or multiple and are well circumscribed. Several morphologic types occur: (1) sessile or common warts are often found on the hands, feet, arms, legs, and digits, and about the nails, face, and neck. They vary in size from a few millimeters to a centimeter or two. They are raised, gray or brown lesions with a rough surface that exhibits black dots or red spots from thrombosed or active papillary vessels (the layman's "seedwart"). (2) Filiform warts, which are a few millimeters in diameter and several millimeters long, occur chiefly about the face, neck and scalp. (3) Plantar warts are often painful and frequently occur at pressure sites. They are usually flat and demarcated from normal skin by a hyperkeratotic ring. Shaving away the horny surface reveals thrombosed or tiny bleeding vessels, a useful point in differentiating callouses or corns. Frequently a number of lesions coalesce to produce mosaic warts. (4) Flat warts are only slightly elevated and are 1 to 3 mm. in diameter. They usually occur about the face, neck and back of the hands. (5) Moist warts (condylomata acuminata) involve anogenital and mucosa most frequently, although they may effect other moist sites such as the conjunctiva or between the toes. These lesions are usually pink or white and they cluster together to produce small or large cauliflower-like growths.

The treatment of warts up until now has been the use of conservative measures to avoid scarring, excessive local irritation, or drug reaction. This has been done by the use of electrodesiccation or freezing with liquid nitrogen or by the use of salicylic acid.

Amantadine HCL is a synthetic chemical unrelated to other anti-infective drugs, and has been used in the prophylaxis of respiratory infections caused by influenza virus strains. Because of its use in this capacity, it was decided that since warts are also induced by virus organisms it would be worth a try in the treatment of warts. Amantadine HCL was

given in the dosage of 100 milligrams twice a day from two to five weeks and in most instances results were extremely satisfactory. The amantadine HCL has been given in approximately 50 cases of both skin warts and plantar warts. In the dosage outlined there has been no toxic effects.

(signed) Murray Levin, M.D.

(See pages 489-490 of the 1967 edition of the Cecil-Loeb *Textbook of Medicine*.)

## Hazard to Practice

June 24, 1972

Dear Editor:

In the June 1972 issue of *The Journal* appears an article, "Management of Brain Tumors" by Ira S. Ross, M.D. It contains a statement: "a fearful hazard to practice is the doctor who makes more money testifying in court than in providing medical care."

The statement, as it stands, provides for no exceptions, and one searches in vain through the article to find any relevance to any part or person. The article is a self-laudatory discourse of the diagnostic and therapeutic

acumen of Dr. Ross, and his resentment when the family of a patient asks for consultation when he makes the diagnosis of brain tumor. In the best television tradition, however, his judgment triumphs over each consultant: one a professor, the other a university hospital.

For some time my income has been mainly derived from testifying in court. In my many years of practice I pride myself on the many patients that I have helped in private practice, and now that I do medicolegal medicine. Many of my colleagues can proudly boast of a similar experience. In behalf of them and myself I repudiate this irresponsible and malicious statement.

A fearful hazard to the practice of medicine is the egocentric and paranoid physician, scornful of consultation and criticism, but free with his criticism of a group of his colleagues without presenting any basis for his charges.

(signed) Saul Lieb, M.D.

---

Dr. Lieb has stated his attitude vigorously.

(signed) Ira S. Ross, M.D.

---

# OBITUARIES

---

## Dr. Joseph B. Basralian

Born in 1901, Joseph B. Basralian, M.D., died on August 14, 1972 at the age of 71. He was an alumnus (1933) of the Medical School at the University of Vermont and did graduate work in his chosen specialty of urologic surgery. He belonged to the American Urologic Association and was director of the Urology Department at the South Bergen Hospital in Hasbrouck Heights. He was attending urolo-

gist at the Hackensack Hospital and a member of our Bergen County Component Society.

## Dr. Thomas H. Boughton

At the grand age of 90, Thomas Harris Boughton, M.D., died on August 13, 1972. A diplomate in pathology, he was a pioneer in New Jersey in this field and had served as director of laboratories at the Mercer Hospital in Trenton. Born in 1881 when Rutherford Hayes was President of the United States, he received his M.D. at the University of Chicago. He had lived in Trenton for years.

#### **Dr. Otto B. Hitschmann**

One of New Jersey's leading dermatologists, Otto B. Hitschmann, M.D., died on July 17, 1972, at the age of 72. He was a 1924 graduate of the Medical School at the University of Vienna and had been chief of his specialty at several hospitals in the Essex County area. He was Assistant Clinical Professor of Dermatology at the Postgraduate Medical School associated with New York University. He was a Fellow of the New Jersey Academy of Medicine and a board diplomate in his chosen field.

#### **Dr. Reuben J. Holland**

A well-known Union County internist died on August 2, 1972. He was Reuben J. Holland, M.D., a 1919 graduate of Fordham University Medical School. Dr. Holland served the people of the Linden (NJ) area for almost half a century. He had had staff appointments at all three hospitals in Elizabeth. He was active in our Union County Medical Society and was a 1969 laureate of the Golden Merit Award of The Medical Society of New Jersey.

#### **Dr. David R. Lyons**

Death came suddenly to David R. Lyons, M.D., on July 26, 1972. He was board certified in pediatrics, but most of his career was in psychiatry. He was chief of that specialty at St. Michael's Hospital in Newark. He retained pediatric affiliations at the Jersey City Medical Center and at the Martland Hospital in Newark. Dr. Lyons was born in 1923 and received his M.D. degree at George Washington in 1946.

#### **Dr. George M. Miller**

On August 16, 1972, George M. Miller, M.D., died at his home in Rahway. A 1936 graduate of Georgetown, he became an internist and was active in the affairs of the Union County Medical Society. At Rahway Hospital he was

an attending in internal medicine. Dr. Miller was 63 years old at the time of his death.

#### **Dr. Harry A. Reinhart**

Harry A. Reinhart M.D., a past-president of the Cumberland County Medical Society, died on June 20, 1972 at the untimely age of 54. Dr. Reinhart was a board diplomate in radiology, and during World War II was a captain in the medical corps of the Army of the United States. He was an active member of the staff at Millville Hospital.

#### **Dr. Eugene J. Slowinski**

At the untimely age of 45, Eugene J. Slowinski, M.D., died on July 25. He received his M.D. degree at Georgetown in 1949. He was an obstetrician and gynecologist—an attending at St. Michael's Medical Center in Newark. From 1961 to 1968 he was Professor and Chairman of the Department of Obstetrics and Gynecology at Creighton University Medical School.

#### **Dr. Richard C. Tomec**

An obstetrician and gynecologist, well known in New Jersey for many years, Richard C. Tomec, M.D., died in Florida on August 17, 1972. He had retired from active practice in 1967. He had been attending surgeon in his specialty at Mountainside and Community Hospitals in Montclair. During World War II, he was a commander in the U. S. Navy. Dr. Tomec was an emeritus member from our Essex County Medical Society.

#### **Dr. Herbert W. Weisman**

Herbert W. Weisman, M.D., died on June 15, 1972 at the untimely age of 55. He received his medical degree in 1943 at Edinburgh. He was an attending surgeon at the Bayonne Hospital and a member of the Hudson County Medical Society. In addition to this prime interest in surgery, he was also much interested in geriatrics and active in the American Geriatric Society.



*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug products useful in treatment involving concomitant use of two or more drugs?**

**Opinion**

**Results of a questionnaire to 7,000 physicians:**

**62.9%**

**Believe combination drug products are useful.**

**13.8%**

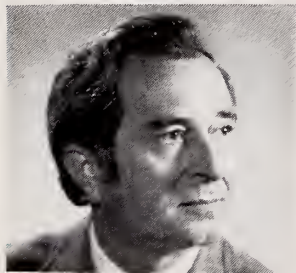
**Do not believe combination drug products are useful.**

# Are combination drug products useful in treatment involving concomitant use of two or more drugs

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in for a number of years and that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I'm thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosage errors. To take such preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it could avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence in making the ultimate decision.



# Maker of Medicine

V. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact, to insist they always be described separately. To avoid the appearance of laziness, the "expert" describes the combination because it is a fixed dosage form. When the "expert" takes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he imposes a pejorative meaning on the term "fixed dose" when he uses it with respect to combinations. That is ignored is the simple fact that only in the best of circumstances may any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains respond to 500 mg. of aspirin yet that fact does militate against the usefulness of being 650 mg. The other semantic ploy called into play is to describe a combination product as rational or irrational. To make antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In judging the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

What is your opinion, doctor?

We would welcome your comments.



The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005



# He won't resist feeling better with **Mylanta**<sup>®</sup>

Because the taste is good.

- ☐ promptly relieves hyperacidity
- ☐ also relieves fullness and bloating
- ☐ non-constipating



LIQUID **MYLANTA**<sup>®</sup> TABLETS

aluminum and magnesium hydroxides with simethicone



STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

---

# BOOK REVIEWS

---

**The Care of Minor Hand Injuries.** Edition 3. Adrian E. Flatt, M.D. St. Louis, Mosby, 1972. pp. 293 (\$21.50)

This book is written primarily for the physician who must treat these injuries but who has limited experience in their care. Such a person can quickly read several pages covering the particular problem and come away with a basic understanding of the principles of treatment.

The book is basically unchanged from the second edition published nine years ago. Certain revisions made consistently throughout the book include changing inches to centimeters, compound fracture to open fracture, procaine to xylocaine as a local anesthetic agent, and a change in the numbering of the charts and illustrations. Several chapters have been updated, such as, the section on tetanus, hand infections, and finger flaps. However, the section on burn therapy makes no mention of the topical agents now so widely used. The section on nerve repair makes no mention of the use of magnification as a great aid and misleadingly states that only a few sutures need be used for the repair.

There are several parts of the book with which I take exception. The author still prefers the thenar flap over the crossfinger flap, even with the likelihood of joint stiffness and a painful scar in the thenar eminence. There is an illustration in which a split thickness skin graft is placed directly on bare bone which is very likely to result in a painful finger tip.

The title of the book is misleading because many of the injuries in the book are major hand injuries which should only be repaired by an experienced surgeon in the operating room. Aside from these minor objections, this is a book full of much basically sound information on the care of a wide variety of hand problems.

Jerome Spivack, M.D.

**Your Money or Your Life.** Richard Kunnes, M.D. New York, Dodd, Mead, 1972. Pp. 118. (\$5.95)

A spate of anti-doctor books has come into the market in the past year. Like most of the others, this charges physicians with being more interested in making money than in treating patients. "It is," Dr. Kunnes suggests, "simpler and more profitable to prescribe the wrong treatment, forcing the patient to return. There is no profit in curing, only in treating."

Other targets of the author's fusillade are unnecessary surgery, the length of the course in medical schools, the AMA (which he once publicly called "The American Murder Association," now gently downgraded to "The American Manslaughter Association"), research (which he says is scarcely relevant to taking care of sick people), the reluctance of medical schools to accept "intellectually curious applicants," limitations on hospital staff privileges ("a monopolistic device for limiting competition"), and a strange monster called "the medical-industrial complex."

Referring to patients "with emotional upsets," Dr. Kunnes explains that the "quack probably does a better job of treating them than does the average M.D." He has a kind word for malpractice suits which, he

assures us, "have done more to raise the standards of medical practice than have technical advances in medical care."

Deploing the length of the medical school curriculum, he reports that "the basic skills needed for examination and treatment can be acquired in six to twelve weeks." At the 1969 meeting, Dr. Kunnes publicly burned his AMA membership card.

This is the work of an angry man, whose grievances are entitled to sober answers, perhaps given less abrasively than his criticisms.

Henry A. Davidson, M.D.

**The Chinese Art of Healing.** Stephan Palos. New York, Bantam, 1972 (original Chinese edition 1963). Pp. 237. Illustrated. (\$1.50)

This book is remarkable in so many ways. It is impressive in the fact that someone could compile the great amount of useful and different information in one volume. Professor Palos did that. It is very complete in providing general and specific knowledge of Chinese medicine in terms of the historical and traditional on one hand and the modern on the other. The section on acupuncture, so much in the press today, is detailed and has many pictures showing points for acupuncture.

The historical aspects of the development of Chinese medicine are outlined in a chart giving one a temporal evaluation sometimes hard to obtain in ordinary text reading. Only a look at a chart forces the mind to realize how old Chinese history is.

The book is printed nicely and has an attractive cover. It has an interesting introduction by William Gunman, M.D. It is both for pleasant leisure reading and is a small reference library with its extensive bibliography. I recommend it to the physician who is in the least bit curious.

Robert K. Spiro, M.D.

**Medical Interviewing: A Programed Manual.** Robert E. Froelich, M.D. and F. Marian Bishop, Ph.D. Saint Louis, Mosby, 1972. Pp. 131. (Softback—\$5)

A good doctor-patient relationship depends on doctor-patient communication. For most of us this is achieved through the interview. Here is a second edition of a highly successful book on the subject. It is a "programed manual," with the reader offered several choices of possible questions or reactions to answers, salted with a discussion of the implications of each approach. In this fashion, Doctors Froelich and Bishop present material on how to initiate an interview, how to assist the patient's narrative without asking leading questions, how to defuse the question that carries an emotional load, how to interview the family, and even how to assay the patient's voice, dress, and posture.

A unique feature of the book is the set of "practice interviews" which details history-taking by skilled clinicians, with explanatory notes as to why the physician worded his question this way or that, or how else he might have worded it, or perhaps how you would have worded it.

In spite of the development of electronic question and answer recording, there is still no substitute for the verbal transaction of the direct physician-patient interview. If the reader will study this text—and not just scan it lightly—he will find his interview technics immeasurably deepened.

Victor Huberman, M.D.

**COLLECTIONS**  
**HENRY-LESLIE ASSOCIATES**

"BONDED"  
P.O. BOX A  
CRANBURY, N. J. 08512  
(609) 395-1760

P.O. BOX 905  
TOMS RIVER, N.J. 08753  
(201) 244-2502

*Professional Services for the Health Professions*  
**NO CHARGE UNLESS WE COLLECT**

**NEW JERSEY**

**FULL TIME                      PART TIME**  
**EMERGENCY ROOM**  
**VARIED SHIFTS AVAILABLE**  
**NEW JERSEY LICENSE REQUIRED**

APPLY: R. J. Matthews, Personnel Director, Point Pleasant Hospital, Osborn Avenue and River Front, Pt. Pleasant, N.J. 08742  
Phone (201) 892-1100

**INDUSTRIAL CLINIC PHYSICIAN**

Wanted for northern N. J. Clinic. Full or part time. Normal work hours—no weekends. Liberal benefits. Submit resume to: Box No. 23, c/o THE JOURNAL.

**INTERNISTS and FAMILY  
PHYSICIANS**

Internists and family physicians badly needed in Atlanta suburb near third busiest airport in world. New offices available adjacent to new 385-bed South Fulton Community Hospital.

Mr. Jim Henderson  
Please contact: Lee-Dixon Realty, Inc.  
5075 Old National Highway  
Atlanta, Georgia 30349  
Phone: (404) 762-8175

**INTERNS NEEDED**

General Practice for 87-bed fully accredited community hospital in Southern New Jersey. E.C.F.M.G. Certificate—\$17,000—Blue Cross/Blue Shield—Midway Philadelphia — Atlantic City 30 minutes away — Opening immediately. Send full particulars to Box No. 21, c/o THE JOURNAL.

**PHYSICIANS WANTED:** Psychiatrist—Immediate openings to work on Psychiatric Services. Also openings in community mental health clinics in need of expansion. Jersey Shore Area. Excellent personnel programs and benefits. May have part time practice. State License required. Salary to \$29,714.00 depending on qualifications. Send resume in confidence to Michael R. Simon, M.D., Medical Director, Marlboro Psychiatric Hospital, Marlboro, New Jersey. Telephone: 201-946-8100.

**PHYSICIANS**

Immediate opening in New Jersey's largest State Hospital, fully accredited by JCAH. Located within 35 miles of NYC. Salary commensurate with experience. Excellent benefits include low cost family housing, retirement pay, paid annual vacation, paid sick leave and health and life insurance. Write Frank D. Fenimore, M.D., Medical Director, Greystone Park Psychiatric Hospital, Greystone Park, N.J. 07950.



# CLASSIFIED ADVERTISEMENTS

**AVAILABLE**—Completing Internal Medicine residency training, Imm. Visa, ECFMG certified. Seeking proper position. Available January 1973. Please contact K. S. Luo, M.D. (201) 753-2000.

**OTOLARYNGOLOGIST**—Solo, associate or group, 32, married, military service completed September 73, board eligible, will consider any location. Write Box No. 29, c/o THE JOURNAL.

**UROLOGY**—Board eligible, military service completed, available July 1973. Franklin A. Morrow, M.D., 1 Wall Street, Fort Lee, New Jersey 07024. Phone (201) 944-8380.

**INTERNIST WANTED**—Board eligible or certified, recent graduate, preferably with subspecialty training, to associate with 3-man, incorporated, internist, subspecialty group in small northern New Jersey city. Please send curriculum vitae. Box No. 28, c/o THE JOURNAL.

**GENERAL PRACTITIONER WANTED**—To practice afternoons and assume hospital work. No investment, immediate income. Bayshore town in Monmouth County. Write Box No. 15, c/o THE JOURNAL.

**PHYSICIAN WANTED**—To cover periodically in industrial clinic. Several days up to two weeks. 9:30-5:30, weekdays, no hospital work. Call (201) 351-6170.

**FOR SALE**—Chatham, New Jersey. Internist leaving established 12 year old successful practice for Arizona. Ideal location, 4 nearby suburban hospitals. Air-conditioned 4 bedroom home, Anthony pool. Six room office combination with laboratory. Office could be used as added living facilities. Large parking area. Corner property, 2 car garage with electric doors. Many built-ins. R. F. Zuch, M.D., c/o W. Schultz, 122 Washington Street, Morristown, New Jersey. Phone 635-5000.

**Information for Advertisers**—**RATES**:—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE**: Fifth of preceding month.

## DIRECTOR OF MEDICAL AFFAIRS

New position in 360 bed JCAH approved community hospital. A challenging opportunity combining teaching, clinical and medical/administrative responsibilities. New Jersey licensure, or license eligibility, required. Salary and benefits open. Provide resumé to J. A. Hammond, M.D., The Mercer Hospital, Trenton, New Jersey 08607.



## GREENBROOK MANOR NURSING HOME

### "A NEW CONCEPT IN GERIATRIC CARE"

Greenbrook Manor offers your patients two levels of nursing care—at commensurate rates—in the same building.

**Intermediate Care**—for the patient who requires minimal care while participating in a well organized and implemented program of social, educational and therapeutic activities.

**Skilled Care**—for the patient who requires intensive supervision and care.

#### OPEN STAFF POLICY

303 ROCK AVENUE  
GREEN BROOK, NEW JERSEY 08812  
(201) 968-5500

"...a more satisfactory treatment..."<sup>1</sup>



# VITAMIN C

## MICRO-DIALYSIS SUSTAINED RELEASE

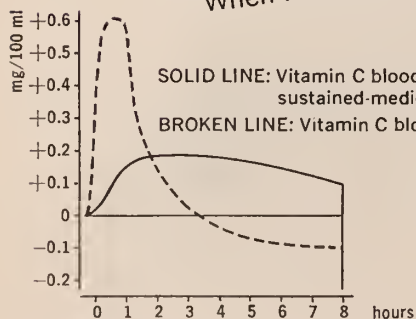
500 mg. CAPSULES

# CEVI-BID

CEVI-BID Capsules permit convenient, b.i.d. dosage for more predictable, sustained vitamin C blood levels all day and night. This avoids the "peaks and valleys" that result from ordinary vitamin C intake (wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels). The unpredictability of enteric-coated vitamin C is also avoided. Cevi-Bid's unique micro-dialysis principle provides release of 500 mg. of vitamin C during a 12 hour period at a smooth, uniform rate.

"This method [CEVI-BID] provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."<sup>1</sup>

When vitamin C is indicated . . . prescribe CEVI-BID.



\*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules).  
\*Adaptation

Samples on Request  
**GERIATRIC PHARMACEUTICAL CORP.**  
 Floral Park, N.Y. 11001  
 Pioneers in Geriatric Research



<sup>1</sup> Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

DEVELOPERS OF GER-O-FOAM • GAYSAL • TESTAND-B

"Prescribe With Confidence"

K A T E S B R O S .

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

*Barefoot . . . Freedom*

SOLD ON Rx ONLY

CORRECTIVE FOOTWEAR FOR MEN . WOMEN . CHILDREN  
OUTFLAIR SHOES FOR CLUB FEET

400 MAIN STREET

HACKENSACK, N. J.

201-487-1779

Dennis Brown Splints — In all sizes — Carried in stock  
CUSTOM SHOE SHOP ON PREMISES

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY  
FORGETFULNESS • CONFUSION



## Cerebro- Nicin<sup>®</sup> CAPSULES

A GENTLE CEREBRAL  
STIMULANT & VASODILATOR  
FOR GERIATRIC PATIENTS

CEREBRO-NICIN<sup>®</sup> double-blind study\*  
shows how some senile symptoms can be treated.  
Four times as many aging patients showed  
striking improvement.

Each CEREBRO-NICIN capsule contains:  
Pentylentetrazole . . . 100 mg. • Nicotinic Acid . . . 100 mg.  
Ascorbic Acid . . . 100 mg. • Thiamine HCl . . . 25 mg.  
L-Glutamic Acid . . . 50 mg. • Niacinamide . . . 5 mg.  
Riboflavin . . . 2 mg. • Pyridoxine HCl . . . 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .

**BROWN** THE BROWN PHARMACEUTICAL CO.  
2500 W. 6th St., Los Angeles, Calif. 90057

\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D.  
Double-blind study on the treatment of mentally confused patients. Reprinted  
from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.



# Librium® and (chlordiazepoxide HCl) concomitant use

Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, anti-hypertensive agents, diuretics, anticholinergics and antacids.

**Antianxiety effectiveness:** Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling

are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable appropriate levels.

**Effect on mental acuity:** Usually minimal on proper maintenance dosage.

**Safety:** An excellent clinical record. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

LIBRARY

OCT 16 1972

NEW YORK ACADEMY  
OF MEDICINE

**in relief of clinically  
significant anxiety**

**Librium®  
(chlordiazepoxide HCl)**

**5-mg, 10-mg, 25-mg capsules  
up to 100 mg daily in  
severe anxiety**

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debili-

tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. These are usually transient and require only adjustment, but are also observed at the lower dosage range. A few instances of syncope have been reported. Also encountered are isolated skin eruptions, edema, minor irregularities, nausea and constipation, extrapyramidal symptoms, i.e., decreased libido—all infrequently controlled with dosage reduction; changes in EEG pattern (fast activity) may appear during treatment; blood dyscrasias (agranulocytosis), jaundice, liver dysfunction have been reported rarely, making periodic blood and liver function tests advisable in prolonged therapy.

**Supplied:** Librium® capsule 5 mg, 10 mg or 25 mg chlcl HCl. Libritabs® tablets contain 10 mg or 25 mg chlrdiazepoxide.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

New York Academy of Medicine  
2 East 103rd Street  
New York, New York 10029 C

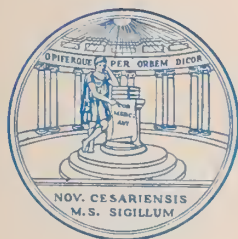
the

## JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

## contents

Pages 897 to 988



## EDITORIALS

Increasing "Life Plan" Dividends	907
Sickness, Illness, Disease	907
The Illnesses of Public Figures	908
Prostaglandins: Drugs of the Future?	908

## ORIGINAL ARTICLES

Vasectomy—Surgery and Symposium	909
Richard Fadil, M.D., Passaic	
Multiphasic Screening—Panacea or Wasted Effort?	919
Stanley Burrows, M.D., Camden	
Carcinoma of the Lung: Improving Surgical Prognosis	927
Ralph J. Lewis, M.D. and Philip J. Kunderman, M.D., New Brunswick	
Major Upper Gastrointestinal Bleeding	933
L. Donald Weinstein, M.D., Hackensack	
Severe Depression Resembling Severe Physical Illness	943
Arnaldo Apolito, M.D., Montclair	
Future Technics of Refraction	949
Aran Safir, M.D., New Rochelle, New York	
Disaster Planning Can Save Lives	953
William A. Dwyer, M.D., Paterson	

## SPECIAL ARTICLE

To Inherit and To Possess	957
Merlin K. DuVal, M.D., Washington, D. C.	

## NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes: September 17, 1972	963
Martland Names New Administrator	965
Physicians Seeking Location	966
Communicable Diseases in New Jersey	967
Medical College Notes	968
Ownership Statement	971
Scientific Exhibits	971

## ANNOUNCEMENTS

LETTER TO THE JOURNAL	979
-----------------------	-----

MEETINGS OF MEDICAL INTEREST	979
------------------------------	-----

OBITUARIES	982
------------	-----

BOOK REVIEWS	984
--------------	-----

NOVEMBER IS LIFE MONTH—

NEW DIVIDENDS ANNOUNCED  
FOR 1973



# The Life Insurance Plan of the Medical Society of New Jersey

**NOW**

**\$150,000  
MAXIMUM**

**MEMBER  
LIFE PLAN AVAILABLE  
ALSO TO SPOUSE,  
DEPENDENT CHILDREN,  
AND EMPLOYEES!**

Your Society extends its members' life insurance protection to also cover spouse, dependent children, and employees, in amounts from \$10,000 to \$50,000 at the same low member rates!\*

- Insurance is non-cancellable with accidental death benefit up to amount of insurance carried (double indemnity).
- ☐ Waiver of premium benefit,
  - ☐ Dividends as declared, and
  - ☐ The right to convert to permanent insurance at any time without evidence of insurability!

\*Dependent child coverage available for ages 15-21 or up to age 26 if a student at an accredited college or university.

**FOR INFORMATION  
CONTACT THE ADMINISTRATOR**

**E. & W. BLANKSTEEN AGENTS  
75 MONTGOMERY ST., JERSEY CITY, N.J. 07310  
(201) 526-1100**



# Isn't this the care you want for your patients?

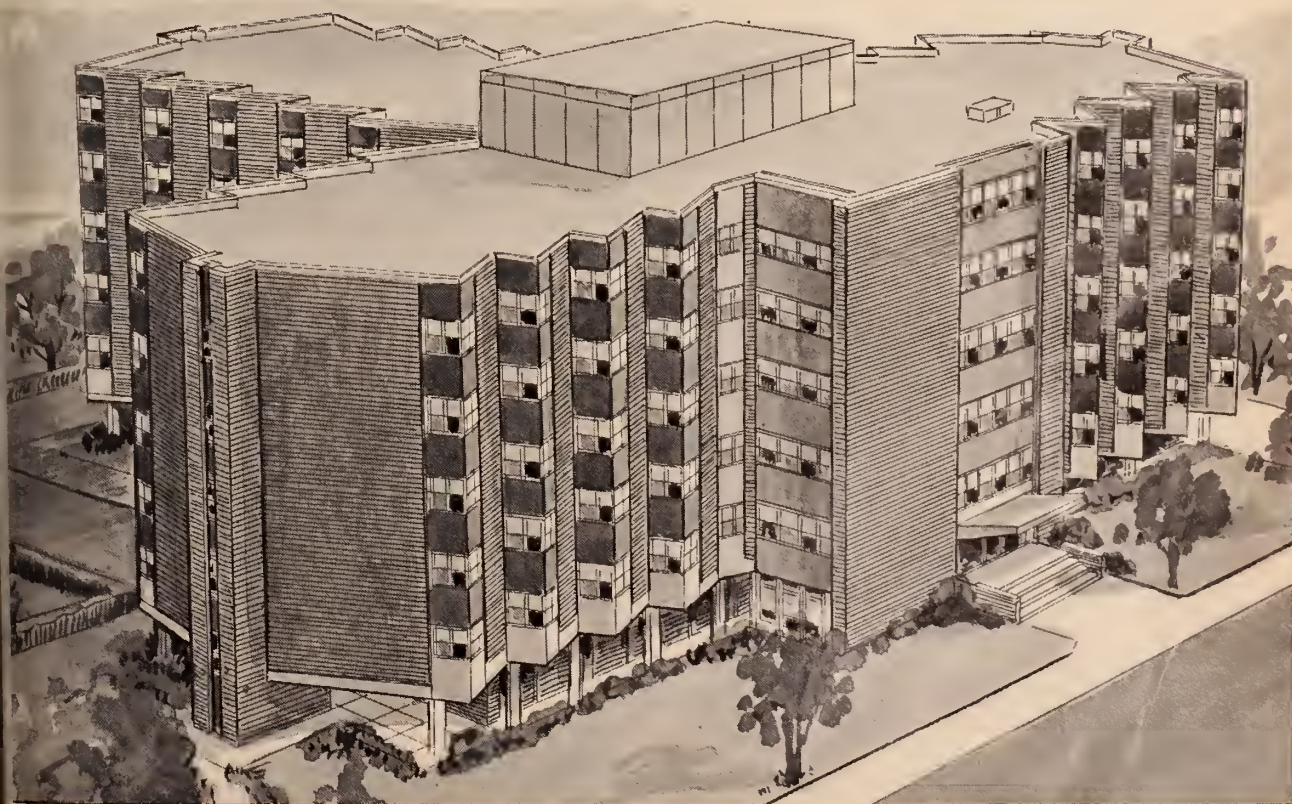
Modern in design and technology, the Messing 250 bed Facility is fully equipped and staffed one-to-one. Our Open Staff policy lets you retain continuity with your Patient. We maintain round-the-clock medical coverage to back you up.

Dedicated Therapists, Nurses and Sociologists provide in-depth treatment aimed at total rehabilitation. The atmosphere is cheery, the rooms spacious . . . each with individually controlled Air Conditioning & Heating. We've a great deal to offer your Patients . . . all for only about 40% the cost of a semi-private hospital room. Non-denominational.

Easy to reach from anywhere. A mile from where Turnpike (Exit 11) & Parkway (Exit 129 South) converge. Near Rtes. 9, 35 & 440. We invite you to investigate.

Messing HEALTH & EXTENDED CARE FACILITY

Corner Smith & Elm Sts., Perth Amboy, N.J. 08861. (201) 826-5600



The negative power of clinically significant anxiety  
in angina pectoris...



This man feels he is living  
on borrowed time.



During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

*Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,\* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)*

*Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.*

The positive power of  
adjunctive  
**Librium®**  
(chlordiazepoxide HCl)  
10-mg, 25-mg capsules  
up to 100 mg daily  
for moderate  
to severe anxiety  
accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

\*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



# THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

## Officers and Trustees

### PRESIDENT

William J. D'Elia, M.D. (Monmouth) ..... Neptune City

### PRESIDENT-ELECT

Matthew E. Boylan, M.D. (Hudson) ..... Jersey City

### FIRST VICE-PRESIDENT

James A. Rogers, M.D. (Passaic) ..... Paterson

### SECOND VICE-PRESIDENT

John J. McGuire, M.D. (Essex) ..... Newark

### IMMEDIATE PAST-PRESIDENT

E. Vernon Davis, M.D. (Burlington) ..... Mount Holly

### SECRETARY

Louis F. Albright, M.D. (Monmouth) ..... Spring Lake

### TREASURER

Samuel J. Lloyd, M.D. (Mercer) ..... Trenton

## Trustees

### CHAIRMAN

A. Guy Campo, M.D. (1973) (Gloucester) ..... Westville

### SECRETARY

David Eckstein, M.D. (1975) (Mercer) ..... Trenton

Robert C. Anderson, M.D. (1975) (Essex) ..... Newark

Francis J. Benz, M.D. (1973) (Morris) ..... Chatham

George L. Benz, M.D. (1974) (Essex) ..... Newark

Edward J. Bourns, M.D. (1975) (Union) ..... Westfield

Harold L. Colburn, Jr., M.D. (1973) (Burlington) Mount Holly

Charles L. Cunniff, M.D. (1975) (Hudson) ..... Jersey City

Richard E. Lang, M.D. (1975) (Passaic) ..... Passaic

Nicholas E. Marchione, M.D. (1974) (Cumberland) Vineland

I. Edward Ornaf, M.D. (1975) (Camden) ..... Camden

Howard D. Slobodien, M.D. (1975) (Middlesex) Perth Amboy

James S. Todd, M.D. (1974) (Bergen) ..... Ridgewood

## Councilors

### FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Thomas S. P. Fitch, M.D. ..... Plainfield (1975)

### SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

John L. Olpp, M.D. ..... Englewood (1974)

### THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. ..... Trenton (1973)

### FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. ..... Haddonfield (1975)

### FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

John S. Madara, M.D. ..... Salem (1974)

## AMA Delegates

Joseph P. Donnelly, M.D. (1973) ..... Jersey City

Frank J. Hughes, M.D. (1974) ..... Gloucester

John E. Kustrup, M.D. (1974) ..... Trenton

Luke A. Mulligan, M.D. (1974) ..... Leonia

Isaac N. Patterson, M.D. (1973) ..... Westville

Emanuel M. Satulsky, M.D. (1974) ..... Elizabeth



November 1972

## Publication Committee

Daniel B. Roth, M.D., *Chairman*  
Arthur Krosnick, M.D.  
John F. Marshall, M.D.

## Editor

Henry A. Davidson, M.D.

## Assistant Editor

Marjorie D. Treptow

## Advertising Manager

Joseph W. Cookson

## Executive Director

Richard I. Nevin

*The Journal* is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 819.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription (\$3.50) is included in the dues of Society members.

Subscription rates for nonmembers: \$7 per year (including postage), in advance. Outside USA, postage is additional.

Single copies are \$1.00 each.

Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

Second class postage paid at Trenton, New Jersey, and additional entry office.

Copyright 1972 by The Medical Society of New Jersey.

# Why send him to the islets of Langerhans?



Since sulfonylureas promote the release of insulin which is lipogenic and helps transport glucose into adipose tissue...

And since many overweight patients already have normal or high levels of endogenous insulin, why not consider DBI-TD?

It lowers blood sugar without stimulating

insulin secretion from the pancreas. And this may be important to the dieting diabetic.

In adult-onset, nonketotic diabetics uncontrolled by diet alone...

**DBI-TD<sup>®</sup> Geigy**  
**phenformin HCl**

lowers blood sugar without raising blood insulin.

**DBI<sup>®</sup> phenformin HCl**  
Tablets of 25 mg.

**DBI-TD<sup>®</sup> phenformin HCl**  
Timed-Disintegration  
Capsules of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:*

This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state.

**Do not give insulin without first checking blood and urine sugar.**

2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic

determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-D (6/72)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of  
CIBA-GEIGY Corporation  
Ardsley, New York 10502

# He won't resist feeling better with **Mylanta<sup>®</sup>**

Because the taste is good.

- ☐ promptly relieves hyperacidity
- ☐ also relieves fullness and bloating
- ☐ non-constipating



LIQUID **MYLANTA<sup>®</sup>** TABLETS

aluminum and magnesium hydroxides with simethicone



STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109



*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug  
products useful in treatment  
involving concomitant use  
of two or more drugs?**

**Opinion**

**Results of a questionnaire to  
7,000 physicians:**

**62.9%**

**Believe combination drug  
products are useful.**

**13.8%**

**Do not believe combination drug  
products are useful.**

# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription — which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in for a number of years that have an apparent satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. Thinking particularly of penicillin-streptomycin combinations that patients — especially surgical patients — were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosing errors. To take such preparation off the market doesn't seem to be good medicine, unless actual age showed a great deal of harm from the injection (rather than the presence) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it is avoid taking the ultimate responsibility, but it should enlist the help of other physicians and experts in assessing the evidence in making the ultimate decision.



# Maker of Medicine

W. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact, to insist they always be described separately. To avoid the appearance of dandyism, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular nomenclature exercise he imposes a pejorative meaning on the term "fixed dose" when he uses it with respect to combinations. What is ignored is the simple fact that only in the best of circumstances is any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains respond to 500 mg. of aspirin yet that fact does militate against the use of a dose being 650 mg. The other semantic ploy called into play is to create a combination product as rational or irrational.

Take antibiotic mixtures, a source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

What is your opinion, doctor?

We would welcome your comments.



The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005





**Not too little, not too much...  
but just right!**

"Just right" amounts of Ilosone Liquid 250  
can be dispensed easily from the pint bottle in *any* quantity  
you specify to meet your patients' precise needs—  
without regard to package size.

ready-mixed  
**Ilosone<sup>®</sup> Liquid 250**

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

*Additional information available  
to the profession on request.  
Eli Lilly and Company  
Indianapolis, Indiana 46206*



100204

---

# EDITORIALS

---

## Increasing "Life Plan" Dividends

November is Life Month. Our administrator has just announced a very substantial dividend increase for policies renewing in 1973. The new dividend schedule is being sent to the entire membership with the annual Life Month mailing. The net cost is the lowest since the plan began fourteen years ago, providing genuine savings for the more than 1,750 participants.

During the past year the maximum was increased to \$150,000 for members—one of the highest limits in the country for such plans. With up to \$50,000 now available for children, spouses, and employees the plan has great versatility to meet our members' needs especially since all policies under the plan are non-cancellable, renewable to age 70, and guaranteed convertible for the full amount at any time!

Since this is Life Month, all eligible members, dependents, and employees are invited to apply—complete information is being sent out by our administrator, E. & W. Blanksteen Agency.

## Sickness, Illness, Disease

"Illness" says Eric J. Cassell\* "is what the patient feels when he goes to the doctor's office; *disease* is what the patient has after leaving the doctor. Disease is something an organ has. Illness is something a man has."

The point is an interesting one, though—semantically at least—not quite valid. The theory is that the patient feels "not right"—perhaps it is fair to say that he feels "sick." The physician then focuses on an organ or tissue and attaches a pathological name to it. This changes it from *illness* (a subjective sen-

sation) to *disease*, which means tissue pathology. Actually, it is not that simple. Etymologically, "disease" merely means "not being at ease," so that, theoretically, it should be the person, not the tissue, that is "diseased." But in modern lexicons, "disease" is an abnormal organ or tissue and it is a doctor's conclusion about the pathology that makes it disease. Not only that, but the physician is viewed as the one who heals "disease" in this modern sense, rather than the one who is adept at making "sick" people feel "at ease." Many cultists certainly owe their success to the management of this kind of "sickness." We often use such terms as "a sick society"—referring perhaps to war, bigotry, poverty, and so on—and we really can't claim for the MD jurisdiction over all these "sicknesses."

Somewhat cognate are concepts of cure, recovery, and healing. As a word, *cure* has the same root as *care* and originally meant "to care for" someone. Again, modern usage has somewhat shifted so today we think of "curing" disease, but "healing" a person. Most of us, actually, avoid the noun "cure" and prefer the less arrogant term "recovery." On the hospital chart, when the patient goes home after having finished his bout of pneumonia, we circle "recovered" not "cured" as the outcome. The word "cured" suggests that we did something to effect a cure, whereas "recovered" suggests that nature took its course.

There is a secondary problem here. Can we "heal" man without "curing" the disease? Well, if the "disease" is a gangrenous limb and we amputate it, then the man feels depressed and deprived. But if he adjusts healthily to a useful new prosthesis, then, in a sense we have "healed" the total person from his sense of disability, but we have not cured the gangrene, except in the whimsical sense of having amputated the whole organ. Our new medical and surgical technologies have improved our skill and success in "curing" diseases, but the more subtle problem of healing the person who feels sick or ill, is not

---

\* Cassell, Eric, M.D., in *Commentary*, 1970.

so much a technological problem as one of making a person feel better even though diseased tissue remains.

In a sense then, the more skilled we become technologically, the more atrophied our emotional skills as "healers." In the various criticisms of the physician, this is, perhaps, the number one doubt—the complaint that we don't give enough time or compassion to the person who doesn't feel right. One wonders what has become of the healer, who responding to a cry for help, used to say: "I'll be right over."

## The Illnesses of Public Figures

The withdrawal this year of Senator Eagleton lights up a frequent medical and ethical problem. If the doctor knows that a prominent public figure has had some kind of medical disability, is the ethical compulsion to reveal it or to ignore it? We know that President Eisenhower had two substantial illnesses while on duty. We know that Woodrow Wilson was significantly disabled during part of his last year in office. Prime Minister Churchill's attending physician gave a great deal of information about the physical and emotional health of his distinguished patient. Grover Cleveland (the only New Jersey native to enter the White House) had a radical operation for a jaw malignancy, the surgery being done on a yacht to assure secrecy. Abraham Lincoln had had frequent spells of depression. By the time a man or woman reaches political prominence he or she is at an age when being heir to many of life's ills is to be expected.

There is a tendency for political decision-makers to react almost reflexly to the knowledge that a candidate has a disability. Thus, Senator Eagleton could produce something that few people have: a psychiatric certificate that he had recovered from a depression. Most candidates can't exhibit any documentary evidence like that. One of the problems here is that some medical diagnoses are especially stigmatic—alcoholism, homosexuality,

syphilis, drug addiction, malignancy, and antisocial psychopathy. While, legally, the patient may waive "privilege," thus releasing the physician to report the details, this doesn't really resolve the ethical dilemma because the subject may not really know how much the doctor has learned about his patient's background, and also because a refusal to waive the "privilege" carries pejorative implications of its own. The dilemma arises because of a conflict between the public's right to know and the patient's right to have a confidence respected. In terms of our basic ethical duties, it would seem that the duty to respect the patient's confidence should take moral priority over any political or tactical considerations.

## Prostaglandins: Drugs of the Future?

British researchers may have discovered what makes aspirin work and opened the door to further exploration of the mysterious family of prostaglandins. Aspirin tends to halt the production of prostaglandins, first discovered in the 1930's. Manufactured all over the body, various prostaglandins can cause fever, inflammation, and headaches—symptoms relieved by aspirin. Although their exact role is still incompletely understood, they are believed to stimulate or inhibit the action of many hormones. They are known to be involved with the functions of the heart, bronchial tubes, blood vessels, and stomach.

In the past few years, six primary prostaglandins have been found, each of them with a number of derivatives. They appear to have a number of uses: the induction of labor; therapeutic abortion; contraception; treatment of male sterility; prevention and therapy of peptic ulcer; treatment of asthma and nasal congestion; and control of high blood pressure.

Laboratories all over the world are studying prostaglandins. An editorial in the *Annals of Internal Medicine* has predicted that, even within the current decade, these substances may become "major therapeutic agents."



---

# ORIGINAL ARTICLES

---

*With 800,000 vasectomies now being done annually in the U.S.A., it is time for a practical, technical manual on the subject. Here Doctor Fadil offers one.*

## Vasectomy — Survey and Symposium\*

---

**Richard Fadil, M.D./Passaic**

When I began my urologic practice in 1962, it was the rare physician who did contraceptive vasectomies. On inquiring, I was told that other urologists, more senior men in the area, didn't do them and therefore we shouldn't. This was unfortunate because following in the unhappy wake of contraceptive failure rates, medical complications, side effects, and unesthetic aspects of non-surgical contraceptives,<sup>1</sup> I can think of no operation that has contributed so much to general marital happiness. I think of none that has done more to influence marital mood in the direction of tranquility, rather than anxiety and tension. Of 1,010 couples surveyed after vasectomy, 57 per cent indicated their marriages were "more harmonious" (42 per cent "no change" and 0.5 per cent "less harmonious").<sup>2</sup> More than 99 per cent of this group had no regrets. The average young couple burdened with the financial and emotional stress of rearing their two or more children finds anxiety enough in our present social milieu. This state is hardly balmed by the period to period worry about another pregnancy, another gestation and labor, another baby to nurture for years, another prospective college tuition.

A cogent deterrent to many who had Catholic hospital affiliations was the fear of incurring the displeasure of Catholic physicians and a significant fraction of the populace in general. Catholic hospitals in fact required agreements avowing the physician would not do sterilizing operations either in the hospital or in his office. That a significant segment of the Catholic laity are unwilling to abide by such

strictures in their choice of contraceptive is evident from the experience of the Association for Voluntary Sterilization of New York City, which, in a recent year, found that in 30 per cent of all couples inquiring about sterilization at least one member was Catholic. A recent study<sup>3</sup> funded by the National Conference of Catholic Bishops disclosed that a majority of Catholic clergy disagree with the teaching that artificial contraception is wrong.

Another factor delaying the popularity of contraceptive vasectomy is misconception about the physiologic consequences of vasectomy. In a questionnaire survey of biology students and faculty at Cornell University, it was asked if vasectomy would abolish the ability to ejaculate. Almost half (49 per cent) confessed ignorance or averred that ejaculation would no longer accompany orgasm.<sup>4</sup> Even among biology students, this ignorance is not surprising considering that many physicians themselves are equally unenlightened. I have been queried cautiously more than once by fellow physicians with this same question in addition to the other common one about the ability to have erections after vasectomy. The fact is a significant number of physicians are not aware of the medical fundamentals of the operation. More unfortunate, they are unaware of the attractions of vasectomy as a permanent contraceptive, and therefore fail to recommend it to patients.

I recall the fear of malpractice litigation being adduced as a real threat. Recent deci-

---

\*Read before the Section on Urology, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 7, 1972.

sions such as the ones<sup>5</sup> declaring unconstitutional anticontraceptive laws in one state have served as a basis for judgments of contrasting sentiment such as that of the legal counsel of the Hospital Association of New York State in an opinion dated July, 1971, that (referring to hospitals) “. . . . . a refusal to perform a sterilization operation can be attacked on constitutional grounds.”

Vasectomy has taken root and flourished, so to speak, in the much less inimical clime of recent years. Witness<sup>8</sup> an increase from 200,000 in 1969 to 750,000 in 1970, one year later. In the non-Catholic hospitals of our immediate area, sterilization of both sexes is now permitted without committee scrutiny, but simply with written informed consent of the patient and spouse. Contraceptive vasectomy after preliminary interview of the patient and spouse, and written informed consent, carries with it no more and probably less likelihood of litigation than other surgical procedures<sup>6</sup> and, in the words of the law department of the American Medical Association,<sup>7</sup> “sterilization poses no greater danger of civil liability than any other medical and surgical procedures . . .”

Because of the fast-rising popularity of vasectomy as a means of contraception, a mail survey of New Jersey urologists was made in early 1972. Questionnaires asked the following:

1. Do you do contraceptive vasectomies? (75 responses)
 

Yes	56	(75%)
No	19	(25%)
2. How many years have you been doing contraceptive vasectomy? (56 responses)
 

1 to 3 years	26	(46%)
4 to 10 years	15	(27%)
11 to 45 years	15	(27%)
3. What ratio do you do in the hospital \_\_\_\_\_? office \_\_\_\_\_? (52 responses)
 

Almost all in hospital	21	(40%)
Almost all in office	31	(60%)
4. Total number in the last 12 months? (50 responses. Varied from 3 to 600)
 

3-10	4	(8%)
10-75	18	(36%)
100+	28	(56%)
5. Proportion of applicants refused. (53 responses)
 

0%	4	(7%)
1-5%	31	(59%)
5-10%	10	(19%)
11-90%	8	(15%)

6. Number of reanastomoses done, if any. (56 responses)

Number done	Number of doctors	(75%)
0	42	(25%) Total 14 doctors and 30 reanastomoses.
1	5	
2	6	
3	1	
4	1	
5	0	
6	1	

Of the respondent New Jersey urologists in this survey 75 per cent are now doing contraceptive vasectomies. Almost half (46 per cent) were doing these for less than three years. Sixty per cent did almost all in the office while 40 per cent did almost all in the hospital. More than half (56 per cent) did over 100 in the 12 months preceding the survey. Seven per cent indicated they refused no applicants while the majority (59 per cent) refused 1 to 5 per cent of applicants. Seventy-five per cent had done no reanastomoses, while most who had could report only 1 or 2.

One need not be a demographer to comprehend that current problems of ecology and pollution are really problems of overpopulation. There are 3.5 billion people on this earth now. The United Nations tells us that 1.5 billion are undernourished and that 0.5 billion are starving. “. . . if current trends are allowed to persist, the breakdown of society and the irreversible disruption of the life-support systems on this planet, possibly by the end of the century . . . are inevitable.”<sup>9</sup> If we wanted the total world population to enjoy the standard of living of the average American, we would have to reduce the population to 500 million, or one-seventh of what it is. Instead, even if the developed world stabilized its population by the year 2000 and other countries by 2040, the world population by the year 2040 will be more than 15 billion.<sup>9</sup>

The National Academy of Sciences tells us<sup>10</sup> that, “. . . the most tragic ills of human existence find their origin in population growth. Hunger, crime, despoliation of the natural beauty of the planet, irreversible extermination of countless species of plants and animals, overlarge, dirty, overcrowded cities with their paradoxical loneliness, continual erosion of limited natural resources, and the

seething unrest which creates political instability that leads to international conflict and war all derive from the unbridled growth of human population."

Dr. Sripati Chandrasekhar, a world famous demographer who has held the post in India of Minister of Health and Family Planning,<sup>11</sup> says that, "The only significant contribution to population control in India has been male sterilization," and that surgical sterilization will be the physical "salvation of India."<sup>11</sup> This claim for vasectomy is no small one but its source could be no more authoritative and certainly it comes from one who should know, the Minister of Health and Family Planning of India.

The average American's response to this information is that overpopulation is a problem of India, of China, of other parts of the world, not of the good old U.S.A., not of his town or city. He is not aware that the census estimates that our population will rise from our approximate 200 million to 300 million in the next 30 years by the year 2000, that all but 10 per cent of our land is in use, that the present 2.5 acres of land per person will be 2.2 acres per person by 1975, three years from now, that below this figure there will have to be some decrease in our general standard of living. Americans, 5 per cent of the world's population, presently consume 50 to 61 per cent of the entire earth's resources (300 times as much plastic as the average Indian, 50 times as much steel, 170 times as much rubber and newsprint, 56 times as much energy as the average citizen of India.) It would seem that we are fiddling contraceptively while "Rome" and the rest of the world burn demographically.

Since 44 per cent of American women in the child-bearing age group experience unplanned pregnancies,<sup>16</sup> and since vasectomy is the contraceptive with the lowest failure rate by far, this should and could be a significant deterrent to the population explosion.

Many variations of vasectomy technic are described.<sup>12</sup> Although the urologist is fully ac-

quainted with vasectomy in the operating room under general anesthesia, he has discovered that it is a somewhat different operation under local anesthesia. This reporter looks back on his first few dozen vasectomies under local anesthesia as technically less than ideal. Time and experience have witnessed a normal metamorphosis, however, to that of a more skilled, confident, and gratified contraceptive vasectomist. The following are aspects of technic I have found worthy of comment:

A nurse serves as assistant and no premedication is used. Most patients are anxious coming for elective genital surgery. I use a simple conversational technic to decrease apprehension. Getting a patient to talk about something he knows well effectively accomplishes this. I inquire about his locale or residence, his children and almost always, I delve into details of his occupation. Once the patient is talking about his occupation and his area of competence, he is most effectively distracted from his apprehensions, becomes self-assured, and tolerates the procedure well. In addition, I enjoy the opportunity to edify myself in other fields.

The vas is palpated, isolated, and entrapped between the thumb, index, and middle fingers. About 0.2 cc. of Xylocaine® is injected intradermally. The needle is then inserted somewhat superiorly and about 0.4 cc. are injected *into* and around the vas itself by one or two passes directly *through* the vas. The closer to the vas, the better the anesthesia and the less anesthetic will be required. The single most important factor in decreasing the incidence of post-operative pain and funiculitis is the minimizing of the volume of anesthetic injected into the spermatic cord. A half-inch skin incision is made, but then left unexplored while the same procedure is carried out on the opposite side of the scrotum. This allows some extra seconds for anesthetic distribution and effect without loss of operating time.

I then return to the side first anesthetized. The vas is again grasped and locked between the thumb, index, and middle fingers. A mosquito clamp is used to spread the tissues around the vas just below the area of vas infiltration. The vas, still locked between the fingers, is rolled over the index finger and between the jaws of an Allis clamp, then grasped and pulled up through the wound. If grasped below the area of anesthetic infiltration, there should be little edema of tissues or vascular friability. A 5 mm. incision is made longitudinally through the sheaths around the vas down to and *into* the vas itself. Occasionally, a vigorous pumper is encountered here and if so it is tied immediately. The vas is then grasped discretely with the Lee vasectomy hook<sup>13</sup> and lifted out of and free of its fascial envelope, grasped more firmly with another clamp. It is essential that no adventitial tissue is lifted out with the vas else the surgery unnecessarily involves the ligating of more intrascrotal tissue with more post-operative pain and morbidity.

Tantalum Hemoclips (Weck Co.) are applied;<sup>12</sup> two to each side of the vas loop and a one centimeter section excised. The clip closest to the transected vas end is applied tightly while the one farther from the transection is applied snugly but not tightly. (I can



control the compression of the vas better with these clips than with a tie.) The ends are dropped back in and the skin closed usually with two or three plain catgut sutures placed so as to contain any subcutaneous bleeders.

Skin slough and infection can be minimized by the following method which obviates the unnecessary inclusion and subsequent slough of skin epithelium while still effectively including substantial segments of bleeding subcuticular and subcutaneous tissue. The straight needle point is placed at the edge of the incision but then passed obliquely away from the skin edge so as to include a larger portion of subcutaneous tissue than epithelium. The reverse of this maneuver is effected on the opposite side to accomplish the same epithelial sparing without excluding subcutaneous bleeders. A Band-Aid® is then applied.

The patient is seen two or three days later, advised to bring a masturbated semen in one month and to continue his contraception till advised otherwise. Usually the one month specimen is azoospermic but a second specimen one month after the first is obtained, and if both are azoospermic, (by slide examination of unspun semen) then he is told that he need no longer use any contraceptive. I then hand the patient an ointment jar and advise him to bring another specimen in two months and then at three month intervals till one year has elapsed. The vagaries of post-vasectomy azoospermia and oligospermia are documented<sup>14, 15</sup> and will be experienced by anyone doing enough vasectomies. However, the format described seems a safe compromise between the extremes of those who examine specimens for only one or two months after vasectomy and those who suggest semen examination every six months for life. The incidence of complications in our hands as well as in those of others is very low and entirely acceptable.<sup>17</sup>

With 40 per cent of American marriages now ending in divorce, and 800,000 vasectomies done in the United States yearly, it is certain that succeeding years will witness the compilation of larger and larger series of reanastomoses, improvements in technic, and higher rates of success than commonly reported. Though "successes" when defined as return of sperm to the ejaculate<sup>18</sup> may approach 90 per cent those defined as "pregnancies" have been reported<sup>19</sup> as low as 14 per cent. Thus, it is best the patients accepted for vasectomy be men seeking permanent contraception with

no equivocation on this point. Although there is no hormonal change after vasectomy,<sup>20</sup> either clinically or by pre- and post-vasectomy hormone measurements, the immunologic phenomenon of post-vasectomy spermagglutination may be operative to decrease the fertility characteristics of semens examined after reanastomosis.<sup>21</sup>

Not all men applying for vasectomy are clearly identified as either acceptable or unacceptable. There are those who sue most ardently for vasectomy but about whom the physician may feel uncertain because of youth, lack of offspring, or some other factor. These persons may change their minds years hence. After extensive interview, deliberation, reflection, and time lapse; if the couple remains resolute and the physician feels they are fully informed, have good insight and are not unstable personalities, he may choose to do the vasectomy after the couple avail themselves of a frozen semen bank facility, indeed an attractive "ace in the hole" so to speak. To any familiar with cattle breeding, the idea of insemination with frozen semen is not strange. Most of the cattle bred in the U.S. now come from frozen semen. The first reports of human pregnancies by artificial insemination with frozen semen were in 1953 by Sherman and Bunge.<sup>22</sup> Since then, over 400 children are reported to have been born of frozen semen and most significantly, without any increased incidence of congenital abnormalities.<sup>23</sup> Frozen semen of 10 year vintage has been used for successful human fertilization.<sup>23</sup>

There are those who augur ill for the vasectomized. Impotence is the most common purported effect adduced. Psychiatric studies<sup>24</sup> have demonstrated that unhappy emotional outcome including impotence is usually a manifestation of a pre-existing psychiatric condition. Certainly impotence is no rare phenomenon in men who have not had vasectomy, so it can be expected to occur in some who have had vasectomy without any causal relationship. But the busy urologist must take the time to interview both spouses to be sure for instance that the husband is not really

reluctant. It is not rare in my experience to meet a husband who really doesn't want an operation on his prized genitalia, (he being fairly content with them as they are) but who is only acceding to his wife's pleading.

Vasectomy is the safest, most convenient, and one of the least expensive birth control methods available. From the patient's personal standpoint, its attraction is validly epitomized by the response of one patient to our routine inquiry, "Why do you want a vasectomy?" when he replied "I'm not looking forward to another 20 years of contraception."

## Bibliography

1. Savel, L. E.: *J. Med. Soc. of N. J.*, 68:635 (1971)
2. Report by Simon Population Trust, 141 Newmarket Rd., Cambridge, England. *Vasectomy Follow-up of a Thousand Cases*, 1969
3. The Catholic Priest in the U.S. The National Opinion Research Center, U.S. Cath. Conf., pp. 101-107, 1972
4. Eisner, T., Van Tienhoven, A., and Rosenblatt, F.: *Science*, 167:3917, (1970)
5. Griswold v. Connecticut, 381 R.S. 479 (1965)
6. Mackay, M. and Edey, H.: *J. Urol.*, 103:482 (1970)
7. Law Department, AMA, Medicolegal Forms with Legal Analysis, p. 28, 1961
8. Lea, Inc., *National Disease and Therapeutic Index*, Ambler, Pa. 1970
9. Blueprint for Survival, *The Ecologist* 2:1 (1971)
10. *Biology and the Future of Man*: The National Academy of Sciences, Oxford Un. Press, 1970, p. 904
11. Chandrasekhar, Sripati: *Population Review*, 12:112 (1968)
12. Moss, W. M.: *Fertil Steril.*, 23:33 (1972)
13. Lee, H. Y.: *J. Korean Med. Assoc.*, 11:335 (1968)
14. Marshall, S. and Lyons, R. P.: *JAMA*, 219:13 (March 27, 1972)
15. Temple, J. G.: *Lancet*, 2:1258 (1970)
16. The Report of the Commission on Population Growth and the American Future, Supt. of Documents, U.S. Govt. Printing Office, p. 97
17. Levine, S. R.: "Vasectomy-Complications in 1395 Consecutive Cases." (Delivered at the First Natl. Conf. on Vasectomy, Chicago, Ill., Oct. 15-16, 1971)
18. Cattolica, E. V.: *Ann Intern. Med.*, 75:475 (1971)
19. Lee, H. Y.: *J. Korean Med. Assoc.*, 13:897 (1970)
20. Bunge, R. G.: *Investigative Urol.*, 10:9 (July 1972)
21. Phadke, A. M. and Padukone, K.: *J. Reprod. Fertil.*, 7:163 (1964)
22. Sherman, J. K. and Bunge, R. G.: *Proc. Soc. Exper. Biol. and Med.*, 82:686 (1953)
23. Sherman, J. K.: (personal communication) Synopsis of the Use of Frozen Human Semen Since 1964. (to be published)
24. Ziegler, F. J.: *Ann. Int. Med.*, 23:853, (November 1970)

124 Gregory Avenue

## Marihuana and Health Brochure

Available from the Superintendent of Documents (U.S. Government Printing Office, Washington, D.C. 20025) is a 150-page brochure titled *Marihuana and Health*. This is identified as the second annual report of the Committee on Labor and Welfare of the U.S. Senate, committee print of the second session of the 92nd Congress. The text reviews the health implications of marihuana use and concludes that a simple answer to this question is not likely to be available in the near future. The evidence shows that in teen-age and young adult circles, marihuana is widely used—in some groups as high as 90 per cent

have used the drug at some time. The report doubts any relationship between marihuana usage and the commission of crimes, but does find that the more emotionally disturbed young people are the ones more likely to take marihuana. Toxicologically, they find that cannabis has a high margin of safety. The drug does seem to cause a deterioration in intellectual and psychomotor performance, which is closely dose-related. The report covers patterns of use in the USA and other cultures and projects future lines of necessary research. The brochure does not indicate its retail price.

"Prescribe With Confidence"

**K A T E S   B R O S .**

**SCIENTIFIC SHOE FITTING**

A Shoe and Last for Every Foot

*Barefoot... Freedom*

SOLD ON Rx ONLY

CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN

OUTFLAIR SHOES FOR CLUB FEET

400 MAIN STREET

HACKENSACK, N. J.

201-487-1779

Dennis Brown Splints — In all sizes — Carried in stock  
CUSTOM SHOE SHOP ON PREMISES

# at H, S & Co., one bond frequently leads to another

Let us introduce you to a winning combination. . . tax-free municipal bonds — expert

knowledge and years of experience. (This is sure to lead to the best available return and a safe secure future for you and your family.)

At Hanauer, Stern & Co. our word is our bond.

Municipal bonds is our business. . . our only business.

For further information call or write

**Hanauer, Stern & Co.** 11 MJ

1180 Raymond Boulevard, Newark, N.J. 07102

N.J. Phone (201) 623-3233

NAME.....PHONE.....  
ADDRESS.....  
CITY.....STATE.....ZIP.....



HERE

Fractures



Wherever it hurts,  
Empirin Compound with  
codeine usually provides  
the relief needed.

HERE

Bursitis



In general, only pain so severe  
that it requires morphine is  
beyond the scope of  
Empirin Compound with Codeine.

**prescribing convenience:**  
up to 5 refills in 6 months,  
at your discretion (unless  
restricted by state law); by  
telephone order in many states.

Empirin Compound with  
codeine **No. 3**, codeine  
phosphate\* 32.4 mg. (gr. ½);  
**No. 4**, codeine phosphate\*  
64.8 mg. (gr. 1). \*Warning—  
may be habit-forming. Each  
tablet also contains: aspirin  
gr. 3½, phenacetin gr. 2½,  
caffeine gr. ½.



**Burroughs Wellcome Co.**  
Research Triangle Park  
North Carolina 27709

# WHEREVER IT HURTS



Low back pain

HERE

# EMPIRIN<sup>®</sup> COMPOUND c CODEINE

#3, codeine phosphate\* (32.4 mg.) gr. ½  
#4, codeine phosphate\* (64.8 mg.) gr. 1





# Break the ulcer circuit to hyperacidity, hypermotility and ulcer pain.

## Pro-Banthine® propantheline bromide A Relief Factor in Peptic Ulcer



Worry, frustration, job pressure—all set up excessive vagal currents in patients with peptic ulcer.

Pro-Banthine "insulates" the stomach, the duodenum and the lower intestinal tract—the sites where these destructive currents take their toll.

This "insulation" helps block excessive enteric activity and acidity, thus helping to provide the proper environment for the healing of peptic ulcers.

It's nice to know that Pro-Banthine provides this protection at a dosage that causes little or no discomfort and that, unlike ataractic agents, Pro-Banthine does not cloud the patient's awareness or thought processes.

By moderating excessive vagal currents Pro-Banthine relieves spasm, acid burn and pain. By reducing gastric motility Pro-Banthine also prolongs the activity of antacids.

**Indications:** Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

**Contraindications:** Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis or unstable cardiovascular adjustment in acute hemorrhage.

**Warnings:** Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with possible loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males

with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

**Adverse Reactions:** Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

**Dosage and Administration:** The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

**How Supplied:** Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE

SEARLE & CO  
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.  
Medical Department, Box 5110, Chicago, Ill. 60680





0.5 Gm tablets  
**ORINASE<sup>®</sup>**  
tolbutamide, Upjohn

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001  
JA72-2407-6

© 1972 The Upjohn Company

*For routine study of healthy outpatients, multiphasic screening seems to Dr. Burrows to be largely wasted effort and money.*

# Multiphasic Screening — Panacea or Wasted Effort?\*

---

**Stanley Burrows, M.D./Camden**

Biochemical screening for the detection of disease has been in use for many years for the detection of diabetes mellitus by the demonstration of hyperglycemia and glucosuria. A more recent program has been the routine determination of blood phenylalanine levels in newborns for the diagnosis of phenylpyruvic oligophrenia. The development of more sophisticated automated instruments in the last few years has initiated an era of multiphasic biochemical screening for the detection of many diseases in both hospitalized patients and in presumably healthy outpatients.

The time is ripe for serious questioning of multiphasic screening programs. Is multiphasic screening worth the effort and cost? Are we using the best choice of tests? Are we detecting a significant amount of previously undiagnosed disease that would not be found by a less elaborate approach? Is there sufficient clinical significance to the abnormalities found? Does multiphasic screening increase the efficiency of medical care? A sufficient number of reports of experience with multiphasic screening programs have appeared in the last few years to provide answers to these questions.

## **Cost and Efficiency**

The cost of introducing automated biochemical screening to a clinical laboratory is considerable, despite the claims of instrument manufacturers to the contrary. The rate of increase of costs of laboratory tests is almost twice that of total hospital costs,<sup>1</sup> and one

must question how much of this is related to the widespread use of automated instruments performing large groups of biochemical screening tests. The initial cost is high, because an instrument capable of performing 12 tests simultaneously is priced at \$70,000. Rental or lease of such instrumentation does not decrease its cost, but spreads payment over a period of time for which the hospital, and ultimately the patient, must pay a premium.

The cost per test procedure is relatively low because of the enormous capacity and speed of the instruments. This is most evident in the laboratory that has sufficient volume to operate the equipment for most of the working day. The cost per test may not be low in a less active laboratory using an instrument like the Technicon SMA 12/60 for only one to two hours each day. Other factors that improve the cost analysis include the ability to absorb increasing work loads without increase of personnel, and the reduced number of separate requests for procedures that are included in the routine test battery. However, routine biochemical screening of *all* patients causes a considerable increase in additional tests because abnormal results from the screening must be repeated and/or additional tests must be performed to determine the significance of abnormalities.

## **What Is Normal?**

The normal range for most laboratory determinations is established so as to include 95

---

\* This work is from The Cooper Hospital where Dr. Burrows is Chief Attending Pathologist.

per cent of the normal population, excluding the upper and lower 2.5 per cent of healthy persons. Therefore 5 per cent of normal subjects will have "abnormal" results for any single test and the use of 20 screening tests will result in at least one "abnormal" test result in about two thirds of normal subjects.<sup>4</sup> It is on this basis that Davey, *et al.*<sup>2</sup> caution practicing physicians to exercise discrimination in their interpretation of laboratory results to avoid unnecessary repeat testing and morbidity from follow-up diagnostic procedures.

Another problem in the establishment of normal ranges involves variation with age. O'Kell and Elliott<sup>5</sup> found that the mean serum glucose, BUN, cholesterol, and LDH increased with age, whereas the mean calcium, phosphorus, total protein and albumin decreased with age in 8,015 hospitalized patients tested in the fasting state. Keating, *et al.*<sup>6</sup> confirmed the decreasing serum calcium and phosphorus with advancing age in their evaluation of blood studies performed on 576 healthy adults, and also noted that sex affected the normal ranges of several other tests. Advancing age was correlated with decreasing serum calcium and phosphorus in men only, and increasing BUN and alkaline phosphatase in women only. Serum phosphorus declined in women from age 20 to 35, but increased after age 40. Therefore, evaluation of laboratory analyses, particularly serum calcium, phosphorus, and alkaline phosphatase, requires a better definition of the normal range relative to both age and sex.

An additional variable that must be considered in the interpretation of screening tests is the effect of drugs.<sup>7</sup> An example of this effect is the occurrence of hyperuricemia in patients taking thiazide diuretics. The physician may not always be aware of all of the drugs being taken by his patients or what effects such drugs may have on each of the screening tests.

Accuracy of the test methods must also be considered. The automated method for cholesterol gives erroneously high results in

the presence of hyperbilirubinemia and erroneously low results in the presence of lipemia, and the suggested corrections for this influence are too variable to assure accuracy.<sup>8</sup> Methodologies are developed within the limitations and compatibilities of automated instrumentation. These are not usually the most accurate or precise methods available. This results not only in a broader range of "normal" for each test, but also occasional spurious abnormal results that may confuse the physician.

### How Many Tests?

The more tests included in the battery of screening tests, the more "abnormal" results will be found. This is partly because of the manner in which the normal range for each test is determined and partly because of true pathologic processes.

Friedman, *et al.*<sup>9</sup> noted that the routine performance of 20 serum biochemical tests in 4,536 patients showed at least one abnormality in 55 per cent of patients, compared to abnormal results in only 27 per cent of 3,910 patients evaluated by only eight tests. The larger number of abnormalities from the larger battery of screening tests resulted in one and a half to two times as many diagnostic entries in the patient records, additional follow-up tests, office visits, phone calls, referrals, therapeutic advice, and prescriptions. They concluded that the expansion of screening tests results in increased laboratory cost, additional work for physicians, additional tests and referrals, and patient worry without definite evidence of their ultimate value for improved health and longevity.

At the opposite extreme, a simple routine urinalysis may be considered a valuable screening test. Macleod<sup>10</sup> performed a routine urinalysis on specimens collected 90 to 120 minutes after the main meal of the day in 1,120 outpatients in general practice. He found 15 new diabetics, 20 patients with albuminuria including 16 who were benefited by proper therapy, and 26 patients with he-



maturia including one with carcinoma of the bladder, two with papillomas of the bladder, and one with a renal stone.

BUN is included in most multiphasic screening studies. However, Kaufman, *et al.*<sup>11</sup> found elevated BUN in only 2.1 per cent of 16,500 adults in a diabetes screening program and showed that 88 per cent of these abnormal results were false elevations as shown by retesting. They concluded that the prevalence of previously unknown azotemia in an outpatient adult population is only 0.2 per cent and such a low prevalence does not justify the routine screening of outpatients for azotemia. In contrast, hemoglobin determinations in screening for anemia in the same group of patients was worthwhile, particularly in women, in whom the prevalence of anemia was 2.1 per cent with only 8 per cent of these shown to be falsely positive on retesting. The prevalence of previously unknown anemia in women was estimated at 1.1 per cent.

Unfortunately, the automated instruments for multiphasic screening lack flexibility. We cannot choose the tests we consider most valuable for screening, nor can we easily change our test battery based on experience. We are more or less "locked in" with a group of tests that is compatible with a particular instrument. The inclusion of serum glucose, uric acid, and cholesterol in the battery provides a good yield of abnormal results, but are we justified in including serum calcium and phosphorus to detect the relatively rare case of hyperparathyroidism just because the instrument has been designed to perform these tests? Mays and Weakley<sup>12</sup> discovered six cases of hyperparathyroidism caused by single parathyroid adenomas, by detection of elevated serum calcium levels in the routine screening of 5,362 hospitalized patients. The inclusion of the serum calcium in screening programs will admittedly result in a considerable increase in the diagnosis of hyperparathyroidism, but the yield is relatively small and the management of asymptomatic hyperparathyroidism is uncertain.

## Clinical Value

The determination of the clinical value of multiphasic biochemical screening must be based upon the clinical significance of biochemical abnormalities rather than the incidence of abnormal results. Unfortunately, many studies have stressed the high incidence of abnormal test results without adequate follow-up studies to assess their clinical significance, and have incorrectly justified the use of multiphasic screening only on the basis of the prevalence of abnormal test results.

Rardin<sup>13</sup> reported that 14.2 per cent of biochemical profiles performed on 1,204 patients in family practice revealed laboratory abnormalities that were related to disease. However, another 25 per cent showed abnormal laboratory results that were *not* related to diagnosed disease. Although he recommends the use of biochemical profiles to provide comprehensive health evaluation in family practice, the study does not clearly indicate the incidence of significant clinical disease that would not have been detected by other means.

Carmalt, *et al.*<sup>14</sup> reported that the use of multiphasic laboratory screening in 296 patients selected at random led to a new diagnosis in 50 patients (17 per cent). However, the new diagnoses included iron deficiency anemia in 40, diabetes mellitus in six, and renal disease in four patients. The same diagnostic yield would have been obtained from the use of only three tests: hemoglobin, BUN, and glucose.

Percy-Robb, *et al.*<sup>15</sup> noted that the routine performance of laboratory screening tests on 1,041 adults seen in general practice detected clinically significant abnormalities in 57 (5.5 per cent), whereas if only those tests that were ordered by the physician had been performed, significant abnormalities would have been found in only 14 of the subjects. However, their screening battery included serum protein-bound iodine and they questioned whether the most appropriate tests are being

done and whether the procedures are reliable.

An abnormal laboratory result is not synonymous with disease. Multiphasic screening for disease has little value unless the program includes follow-up diagnosis and therapy. Schneiderman, *et al.*<sup>7</sup> found that follow-up of abnormal serum alkaline phosphatase, SGOT, BUN, and bilirubin levels detected in the biochemical screening of 547 outpatients did *not* lead to specific diagnoses during a 6 to 12 month period of observation, regardless of the extent of the laboratory abnormality. They noted that doctors tended to disregard an abnormal laboratory screening result, considering that it was clinically insignificant or without interpretation.

Barnett<sup>16</sup> has stressed that the problems of multiphasic screening include not only the relative frequency of diseases detected, but also their amenability to prevention or treatment. How many patients can be identified who have potentially curable or reversible disease at an early asymptomatic phase? Ahlvin<sup>3</sup> doubts that the diagnosis of asymptomatic diabetes mellitus, hyperuricemia or uremia permits any significant change in the course of the disease. Korvin and Pearce<sup>17</sup> question whether the earlier diagnosis of chemical diabetes, hyperuricemia or myelomatosis or the finding of abnormal liver function tests in the patient with carcinomatosis or alcoholism are of any practical value.

Thorner<sup>18</sup> noted that the best results of multiphasic screening for disease have been reported in higher social and economic groups with proper orientation and access to medical care and who may have received good medical care and early diagnosis without a special multiphasic screening study. He stresses that the screening would have the greatest potential in a low economic or social group, which unfortunately shows the lowest participation rate in the multiphasic screening programs and is least likely to have proper diagnostic and therapeutic follow-up.

Korvin and Pearce<sup>1</sup> have found that an abnormal result on a test that has been specifically requested is more likely to be significant than the same abnormal result obtained as part of a screening program. In addition, if a normal result is obtained on a test that has been repeated because of a previously marginal abnormal result, the normal result is probably the correct one.

Many of the doubts about the value of multiphasic screening apply largely to outpatients. Hospitalized patients should be considered in a separate category.

Hospitalized patients are either obviously ill at the time of admission, have diagnostic problems, or will undergo elective surgery. These patients use expensive facilities and any reasonable approach that improves diagnosis and hastens proper care is valuable. The routine availability of a battery of laboratory screening tests within a few hours of hospitalization may appreciably shorten the average hospital stay. Patients admitted for elective surgery may have significant subclinical disease that would preclude general anesthesia or the surgery planned, but such disease may not be detected preoperatively without a battery of biochemical screening tests. Even a normal result may help in the diagnosis of an ill patient<sup>5</sup> and correlation of tests performed at the same time may help in diagnosis and exclusion of certain diseases.<sup>14</sup>

In addition, there are some benefits to the efficiency of a hospital laboratory from routine biochemical screening of hospitalized patients. Physicians make fewer requests for individual tests included in the routine studies because these tests are performed automatically. Requests for individual tests become more limited to those needed to check abnormal results, follow changing clinical situations or to those tests that are not included in the routine biochemical screening battery.

## Conclusions

Multiphasic biochemical screening in its current form is probably not justified for the

routine study of healthy outpatients. The cost is high relative to the actual yield of significant preventable or treatable disease. In addition, the interpretation and follow-up of abnormal results in healthy outpatients leads to increased demand on the medical care system including the critical area of physician utilization. Multiphasic biochemical screening probably does serve a useful function for ill and hospitalized patients for whom rapid and accurate diagnosis is more critical, yield of significant abnormalities is relatively high, and laboratory efficiency is improved.

Multiphasic screening is neither panacea nor wasted effort. Its value can be more fully realized with more discriminate use.

## Bibliography

1. Griner, P. F. and Liptzin, B.: *Ann. Intern. Med.*, 75:157 (1971)
2. Davey, P. W., Letts, H. W. and Anderson, P. A.: *Canad. Med. Assn. J.*, 103:140 (1970)
3. Ahlvin, R. C.: *New Eng. J. Med.*, 283:1084 (1970)
4. Korvin, C. C. and Pearce, R. H.: *Canad. Med. Assn. J.*, 105:1157 (1971)
5. O'Kell, R. T. and Elliott, J. R.: *Clin. Chem.*, 16:161 (1970)
6. Keating, R. R., Jones, J. D., Elveback, L. R., et al.: *J. Lab. Clin. Med.*, 73:825 (1969)
7. Schneiderman, L. J., DeSalvo, L., Baylor, S., et al.: *Arch. Intern. Med.*, 129:88 (1972)
8. Moline, C. and Barron, E. J.: *Clin. Chem.*, 15:521 (1969)
9. Friedman, G. D., Goldberg, M., Ahuja, J. N., et al.: *Arch. Intern. Med.*, 129:91 (1972)
10. Macleod, M.: *Lancet*, 1:1167 (1970)
11. Kaufman, B. J., Grant, D. R. and Moorhouse, J. A.: *Canad. Med. Assn. J.*, 100:744 (1969)
12. Mays, E. T. and Weakley, S. D.: *Surg. Obstet. Gynec.*, 133:603 (1971)
13. Rardin, T. E.: *JAMA*, 214:1262 (1970)
14. Carmalt, M. H. B., Freeman, P., Stephens, A. J. H., et al.: *Brit. Med. J.*, 1:620 (1970)
15. Percy-Robb, I. W., Cruikshank, D., Lamont, L., et al.: *Brit. Med. J.*, 1:596 (1971)
16. Barnett, R. N., Civin, W. H. and Schoen, I.: *Amer. J. Clin. Path.*, 54:483 (1970)
17. Korvin, C. C. and Pearce, R. H.: *Canad. Med. Assn. J.*, 105:1053 (1971)
18. Thorner, R. M.: *New Eng. J. Med.*, 280:1037 (1969)

The Cooper Hospital

## Medicinal Information Center

Funds have been awarded by the New Jersey Regional Medical Program to evaluate the expansion of the Medicinal Information Center from the present service area of the Valley Hospital in Ridgewood to the Comprehensive Health Planning Area I (Hudson, Bergen, Passaic, and Sussex Counties).

The project coordinator is Jack M. Rosenberg who holds a doctorate in pharmacy. Purpose of the Medicinal Information Service is to provide therapeutic and pharmaceutical information to health professionals at no charge to them. Specific objectives are to provide health professionals of Bergen, Passaic, Hud-

son, and Sussex Counties with comprehensive and authoritative information about medicinal products, and to make the information readily available with a minimal amount of involvement by the inquirer. A news bulletin containing the latest developments concerning medicinal agents will be published and distributed to health professionals within the service area. More information can be requested from this bulletin if desired. To date the Center has received 800 questions, most from physicians, concerning drug interactions, adverse effect, compatibilities, therapeutic use, and the like. The Center is available seven days a week (201) 445-4900, ext. 306.



# Announcing Roche Clinical Laboratories

Professional  
Consultation

An Advanced  
Diagnostic Center for  
Standard, Endocrine  
and Special Laboratory  
Tests

Automated Diagnostic Analysis  
for most tests



# A New Commitment in Health Care

A new technological achievement that offers a broad scope of diagnostic testing. Designed to provide you, your patients and your hospital with highest quality test standards for better health-care delivery.

Simplified specimen preparation, daily pickup or prepaid mail, and permanent report forms are all part of this rapid, accurate diagnostic service.

The Roche Professional Representative welcomes the opportunity to introduce our laboratory service to you. Please fill in the coupon below for additional information.

Computerized  
Quality Control  
to prevent error

Personal Service through  
Roche Professional Representatives

ROCHE

Roche Clinical Laboratories  
1 Fairfield Crescent  
West Caldwell, New Jersey 07006

Gentlemen

I am interested in learning more about  
Roche Clinical Laboratories Services

- ☐ Please send the Roche Clinical  
Laboratories Reference Manual
- ☐ Please have a Roche Professional  
Representative contact me

Doctor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Tel No \_\_\_\_\_

A Unique Professional  
Staff of Research  
Scientists and Practicing  
Clinicians

---

# Here Are the Facts on Fee Disputes Under the Prevailing Fee Program

---

In cases where there is a fee dispute involving a Blue Shield subscriber enrolled under the Prevailing Fee Program in the motors, steel or rubber industry:

1. Blue Shield never has initiated, and never will initiate, legal action against a physician to settle such a dispute.
2. Blue Shield, following the edicts of the American Medical Association and The Medical Society of New Jersey, on behalf of the patient seeks peer review through the judicial mechanism, i.e., the County Medical Society Judicial Committee and the Judicial Council of The Medical Society of New Jersey. Blue Shield will accept the verdict of the judicial mechanism as final.

Only when the physician avoids the judicial mechanism and brings suit against the patient, then and only then will Blue Shield offer legal assistance to the patient.

Blue Shield firmly agrees with the recommendations of the American Medical Association and The Medical Society of New Jersey that disputes of this nature be settled in Judicial Committees and Judicial Council, and not in the courts, which can result in unnecessary publicity which frequently is adverse to the entire profession.

In paying almost one million claims under Prevailing Fee, Blue Shield has provided legal assistance to a patient only three times. In each case the physician had not agreed to go to peer review, but initiated legal action instead.

Prevailing Fee is regarded by physicians and subscribers as a great advance over the basic fixed fee program. In their own interest, all members of the medical profession should evaluate carefully the validity of criticism of the Prevailing Fee Program voiced by a few physicians.



## **BLUE SHIELD**

Medical-Surgical Plan of New Jersey



*Early surgical resection may be followed by favorable results in carcinomata of the lung.*

# Carcinoma of the Lung: An Improving Surgical Prognosis

---

**Ralph J. Lewis, M.D. and Philip J. Kunderman, M.D./New Brunswick\***

Periodically, a wave of defeatism develops, engulfing a disease process which does not rapidly respond to available methods of treatment and leads to a nihilistic philosophy engendering a "do-nothing" attitude. Such thinking frequently arises concerning carcinoma of the lung. This, many times, results in delay or omission of treatment, preventing a possible cure, or, at least, palliation for the afflicted patient. It is wrong and harmful to deny a patient the methods available for treating carcinoma of the lung merely because these methods do not always produce a long-term cure.

Because of these attitudes and our interest in this problem, we decided to review the results obtained from a group of patients operated upon about four years ago. During this period, we began to utilize mediastinoscopy routinely with bronchoscopy in order to evaluate all suspected cases of carcinoma. Since that time, over 400 mediastinoscopies have been done, and this procedure has revealed that 33 per cent of all patients who appear operable by all other criteria (bronchoscopy, lung scan, pulmonary arteriography, bronchography, brain scan, liver scan) have mediastinal lymph node invasion and in reality are unresectable and incurable. Mediastinoscopy has enabled us carefully to select those patients who have mediastinal metastases and reject them as surgical candidates. This single procedure has decreased the number of thoracotomies performed by 33 per cent, but also has increased our resectability rate from 70 per cent to 93 per cent. Since the initiation

of mediastinoscopy, we have been operating on fewer patients, but resecting a much greater percentage of lesions.

In view of these findings, we reviewed the patients operated upon during the first year this new modality was utilized, in order to determine if better selectivity could produce a better survival rate. The group is numerically small, but at least allows a four-year follow-up. All patients were considered operable and resectable at the time of preoperative evaluation and over 90 per cent actually were resected.

Epidermoid carcinoma was the most common primary malignancy of the lung encountered. Eleven patients who did not have lymph node metastases were resected and seven are still living for a four-year survival rate of 63 per cent. Seven patients had nodal metastases at the time of resection and only two are surviving for a cure rate of 28 per cent.

Resected adenocarcinoma without nodal metastases resulted in five out of seven patients who are still surviving for a 71 per cent cure rate. Only one of six patients with nodal metastases survived, giving a 16 per cent cure rate.

Interestingly, there was one patient with oat cell carcinoma who did not have metastases and that patient still survives four years later.

---

\* This work is from the combined cardiothoracic services of the Middlesex and St. Peter's General Hospitals, New Brunswick, New Jersey, where Dr. Lewis, who is also Assistant Clinical Professor of Surgery, New Jersey College of Medicine and Dentistry, is attending surgeon, and Dr. Kunderman is chief of the cardiothoracic services.

Eleven patients with oat cell carcinoma or undifferentiated carcinoma with metastases to the lymph nodes were operated upon and only two survived (18 per cent) for four years.

One patient who underwent resection for alveolar cell carcinoma without nodal metastases is still surviving whereas two patients with nodal metastases have died. No patient requiring a radical pneumonectomy with extensive mediastinal dissection or chest wall resection has survived four years.

These statistics certainly contradict the hopeless attitude manifested by many physicians who see only one or two cases of carcinoma of the lung a year. Since their particular patients might not do well, it is the general feeling that all patients do poorly.

Actually, 60 to 70 per cent of all patients who underwent resection for epidermoid or adenocarcinoma (and did not have nodal metastases) were still surviving four years later. Only 15 to 20 per cent with the same pathology, but with metastases to the nodes, will survive four years. Even oat cell carcinoma without nodal metastases had a favorable prognosis, whereas, with nodal metastases, the prognosis became poor, but not hopeless (18 per cent).

These statistics reveal that surgical resection

or carcinoma of the lung is not a futile endeavor. If a patient could be resected before nodal metastases occur there is an excellent opportunity for survival despite the type of pathology found. If this same patient is observed until his lesion is seen to grow on x-ray or debilitating symptoms develop, allowing time for spread to the mediastinal nodes, then his chance for a cure is severely reduced.

Obviously, the earlier the lesion is resected the better the cure rate and since mediastinoscopy has been employed, the need for exploratory thoracotomy in order to determine operability has been almost completely eliminated. Better selectivity of patients for surgery has resulted in a much higher cure rate. The physician initially seeing the patient must be acutely aware of the difference in survival rates when the nodes are negative as compared to when they are positive. Rather than adopting a philosophy of defeatism and denying the patient a potential cure, one should strive to diagnose carcinoma of the lung at its earliest stages, hopefully, before nodal metastases occur. Since long-term survival is tantamount to early diagnosis and surgical resection, it would behoove every physician to initiate early treatment for his patients with lung lesions. When this can be accomplished, a much higher rate of survival of patients with carcinoma of the lung will be seen. Neglect or delay in treatment will uniformly produce poor results.

185 Livingston Avenue

### Resuscitation In Coronary Care Units

A film which demonstrates the practice of cardiopulmonary resuscitation within the coronary care unit has been produced by Pyramid Films in cooperation with the American Heart Association. Produced under medical direction of Archer S. Gordon, M.D., it is entitled "Life in the Balance." The film shows how the coronary care unit can

provide for the prevention, detection, and treatment of serious arrhythmias, cardiogenic shock, and cardiac arrest. It is a 16 mm. 27-minute color film. It may be purchased through Pyramid Films, Box 1048, Santa Monica, California 90406, or rented from the Heart Association's Film Library, 27 West 25th Street, New York 10010.



# FAIR OAKS HOSPITAL

and

## ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

Sergio D. Estrada, M.D., Medical Director  
Oscar Rozett, M.D., Medical Administrator  
Miss M. M. Kennedy, R.N., B.S., Director, Nursing Service

Granville L. Jones, M.D., Director of Research  
Felix A. Ucko, M.D., Director, Adolescent Program

Electro and Indoklon shock therapies. Insulin coma therapy. Pharmacotherapy. Individual and Group psychotherapy. Complete Occupational, Recreational, and Social Service Departments.

For descriptive literature write Thomas P. Prout, Jr., Administrator



TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

**APATHY • IRRITABILITY  
FORGETFULNESS • CONFUSION**



## Cerebro- Nicin<sup>®</sup> CAPSULES

**A GENTLE CEREBRAL  
STIMULANT & VASODILATOR  
FOR GERIATRIC PATIENTS**

**CEREBRO-NICIN<sup>®</sup> double-blind study\***  
shows how some senile symptoms can be treated.  
Four times as many aging patients showed  
striking improvement.

Each CEREBRO-NICIN capsule contains:  
Pentylentetrazole ..... 100 mg. • Nicotinic Acid .... 100 mg.  
Ascorbic Acid ..... 100 mg. • Thiamine HCl ..... 25 mg.  
L-Glutamic Acid ..... 50 mg. • Niacinamide ..... 5 mg.  
Riboflavin ..... 2 mg. • Pyridoxine HCl ..... 3 mg.

AVAILABLE: Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.

**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

**CONTRAINDICATIONS:** Epilepsy or low convulsive threshold.  
**CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

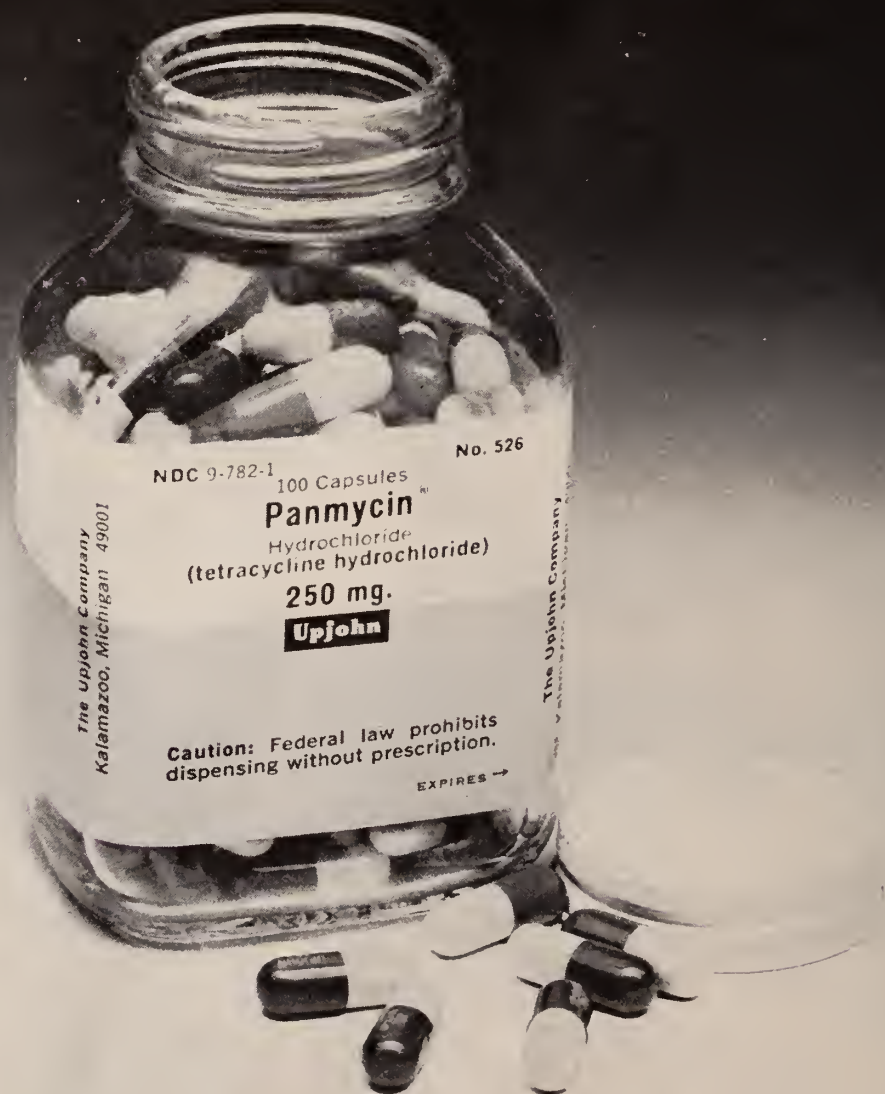
Write for literature and samples

**BROWN THE BROWN PHARMACEUTICAL CO.**  
2500 W. 6th St., Los Angeles, Calif. 90057

\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D.  
Double-blind study on the treatment of mentally confused patients. Reprinted  
from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.



# Upjohn's low-priced tetracycline



## Panmycin<sup>®</sup>

(tetracycline HCl, Upjohn)

Available as 250 mg capsules and  
tetracycline syrup 125 mg/5 ml

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2142-6

# PUSH-BUTTON PAIN RELIEF



in RHEUMATOID and OSTEOARTHRITIS

## GER-O-FOAM<sup>TM</sup> AEROSOL FOAM FOR MASSAGE

methylsalicylate 30% and benzocaine 3% in a specially processed emulsion

Ger-O-Foam reduces pain<sup>1</sup> when its surface analgesic-anesthetic foam is massaged into the skin. This relief from pain facilitates increased range of motion in joints affected by rheumatoid or osteoarthritis, making prescribed exercise easier to perform. With Ger-O-Foam, pain relief occurs in minutes . . . lasts for hours.

**PRECAUTIONS:** Do not use in or near eyes, on open wounds or mucous membranes. Discontinue if excessive irritation of the skin develops.

**AVAILABLE:** 1½ and 4 oz. cans. Approximately 125 applications in each 4 oz. can.

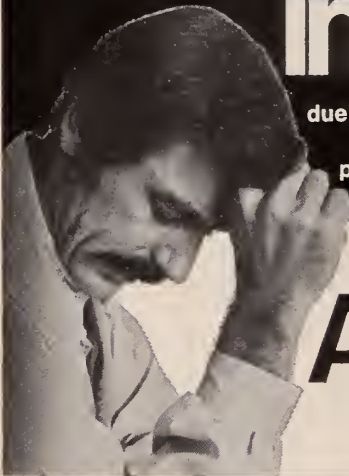
1. Gordon, E. E. and Haas, A., *Indust. Med. & Surg.* 28:217, May, 1959.



**GERIATRIC PHARMACEUTICAL CORP.**  
397 Jericho Tpke., Floral Park, N.Y. 11001  
Pioneers in Geriatric Research



DEVELOPERS AND SUPPLIERS OF CEVI-BID • GAYSAL • TESTAND-B




The treatment of

# impotence

due to androgenic deficiency in the American male.


The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.



The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970. Official Journal of the American Fertility Society

# Android

(thyroid-androgen) tablets



**Double-Blind Study and Type of Patient:**

100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

**Choice of 4 strengths:**

**Android**

Each yellow tablet contains:

Methyl Testosterone . . . 2.5 mg.

Thyroid Est. (1/6 gr.) . . . 10 mg.

Glutamic Acid . . . . . 50 mg.

Thiamine HCL . . . . . 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

**Android-HP**

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone . . . 5.0 mg.

Thyroid Est. (1/2 gr.) . . . 30 mg.

Glutamic Acid . . . . . 50 mg.

Thiamine HCL . . . . . 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

**Android-X**

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone . . . 12.5 mg.

Thyroid Est. (1 gr.) . . . 64 mg.

Glutamic Acid . . . . . 50 mg.

Thiamine HCL . . . . . 10 mg.

Dose: 1 or 2 tablets daily.

Available:

Bottles of 60, 500.

**Android-Plus**

WITH HIGH POTENCY

B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone . . . 2.5 mg.

Thyroid Est. (1/6 gr.) . . . 15 mg.

Ascorbic Acid (Vit. C) . . . 250 mg.

Thiamine HCL . . . . . 25 mg.

Pyridoxine HCL . . . . . 5 mg.

Niacinamide . . . . . 75 mg.

Calcium Pantothenate . . . 10 mg.

Vitamin B-12 . . . . . 2.5 mcg.

Riboflavin . . . . . 5 mg.

Dose: 2 tablets daily.

Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montasano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:59, 1965. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:57, 1964. 3. Tillet, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:5, 1962. 4. Melman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interactions and the hypohypothalamic effect of androstenedione. J Clin Endocr 19:596, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Dodo, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1955, pp. 79-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057



# Major Upper Gastrointestinal Bleeding\*

## A Retrospective Study of Diagnostic Approach at a Community Hospital

**L. Donald Weinstein, M.D./Hackensack**

Massive bleeding from the upper gastrointestinal tract is a serious problem requiring skillful decision and careful judgment. Prompt and accurate diagnosis of the site and nature of bleeding is essential in determining effective therapy.

An active philosophy of vigorous diagnostic management has evolved to cope with the problems of the bleeding patient, with specific emphasis on early endoscopic and radiologic examination.<sup>1,2</sup> In an attempt to assess the approach and specific methods used in the diagnosis of major upper gastrointestinal bleeding at Hackensack Hospital, the following retrospective study was undertaken.

### Material and Methods

The case records of all patients admitted to the medical and surgical services at Hackensack Hospital during 1970 were reviewed by coding procedure for the following criteria of *major upper gastrointestinal bleeding*:

1. Final diagnosis indicating upper gastrointestinal bleeding site or lesion, suspected or proved.
2. Transfusion of four or more units of blood.
3. Hematemesis and/or melena.

Data concerning age, sex, admission hematocrit, number of units of blood transfused, admitting service, surgical exploration, and mortality were recorded. Specific attention was directed to the diagnostic approach and procedures used in determining the etiology

of bleeding: endoscopy, radiology, surgery, and consultation. This information was examined from the standpoint of both diagnostic procedure as well as specific cause to elucidate the basic approaches used in determining the site and nature of bleeding.

### Results

The records of fifty-four patients fulfilled all three criteria and were selected for the study of diagnostic aspects of major upper gastrointestinal bleeding. The patients ranged in age from twenty-five to eighty-six years, (average age fifty-eight years). Thirty-nine were male and fifteen female. Forty-nine of the fifty-four patients were admitted to the hospital on one occasion, four patients on two occasions, and one patient on three occasions for recurrent major upper gastrointestinal bleeding during 1970. The admission hematocrit varied from fourteen to forty-one, with an average of twenty-five. The number of units of blood transfused ranged from four to thirty-two with an average of ten units transfused per patient.

Table I indicates the number of units of blood transfused per patient according to bleeding site, treatment, and mortality. Nine of the fifty-four patients in the study died during their hospital stay (16 per cent mortality). Average age of this group was fifty-two years. Average units of blood transfused was fourteen per patient.

\* From the Hackensack Hospital, Hackensack, New Jersey.

		Table I						
		Peptic Ulcer	Gastric Ulcer	Varices	Gastritis	Stress Ulcer	Unknown Site	CA
Number of units of blood/patient.	35							
	30			S		S		
	25			S S				
	20			M			M	
		S			S	M		
		M						
	15	M		S		S		
				M M		M		
	10	S S						
		S			M			
		M						
			M	M	S		M	
		M S M M M M M S		M	M M		M	
	5	M S M M		S	M		M	
	S M M S M M	M	M	M		M M	S	

Number of units of blood transfused per patient; according to bleeding site and treatment.

M = Medical treatment, S = Surgical treatment,  
M = Medical Mortality, S = Surgical Mortality.

Thirty-five patients were treated conservatively. Five patients in this group died during their hospital stay (14 per cent mortality). Nineteen of the fifty-four patients underwent surgical exploration for diagnosis and management of major upper gastrointestinal bleeding (35 per cent). Four of these nineteen patients expired post-operatively (21 per cent surgical mortality).

Of the forty-three patients initially admitted to the medical service fourteen underwent surgical procedures for control of bleeding (32 per cent). Four of these patients died during their hospital stay. An additional three patients admitted to the medical service and treated conservatively expired during their hospitalization.

Eleven of the fifty-four patients were initially admitted to the surgical service. Five of these patients underwent surgical procedures for control of bleeding (45 per cent). There were no deaths within this group. Two patients treated conservatively in the surgical service expired.

# Analysis by Disease Process

(See Table II for Summary of Results)

*Peptic Ulcer Disease:* Twenty-six (46 per cent) of the patients were considered to have major upper gastrointestinal bleeding due to peptic ulcer disease. The diagnosis was made in all patients on the basis of the clinical history with radiologic confirmation. This group of patients included twenty-four with acute and chronic duodenal ulcer disease and two with stomal ulcers.

Twenty-one of these patients were initially admitted to the medical service; five to the surgical service. Nine patients underwent surgical intervention; one patient died post-operatively. Post mortem examination in this case confirmed peptic ulcer disease and revealed multiple endocrine adenomatosis, unsuspected preoperatively. One patient with recurrent bleeding due to stomal ulceration had clinical findings strongly suggestive of Zollinger-Ellison syndrome and underwent a total gastrectomy.

Consultation was sought in seventeen of these twenty-six patients; fifteen consultations from the surgical service and two from the gastroenterology service. The two patients seen in consultation by the gastroenterologist underwent endoscopy.

Table II

Diagnosis	No.	Per Cent	Service	Endo	X-ray	Consult	Surgery	Mortality
Peptic Ulcer	26	46	M: 21 S: 5	2	26	S: 15 G: 2	9	1 (4%)
Gastric Ulcer	2	4	M: 1 S: 1	2	2	G: 2	0	0
Varices	9	16	M: 7 S: 2	5	6	S: 4 G: 3	5	4 (44%)
Erosive Gastritis	6	12	M: 4 S: 2	4	5	S: 2 G: 3	2	0
Malignancy	1	2	S: 1	1	1	S: 1	1	0
Stress Ulcer	4	8	M: 1 S: 3	0	1	S: 2	2	3 (50%)
Unknown Cause	6	12	M: 5 S: 1	2	4	S: 1 G: 2	0	2 (33%)
Total	54	100%	M: 43 S: 11	16	45	S: 25 G: 12	19	9 (16% avg.)

M = Medical Service

S = Surgical Service, Surgical Consultation

G = Gastroenterologic Consultation

Summary of data according to diagnosis. Number and percentage of patients, admission service, diagnostic procedures, consultation, surgery and mortality.

The ingestion of salicylates was recorded in the clinical and/or consultation note in ten of these twenty-six patients. None was endoscoped.

*Gastric Ulcer Disease:* Two patients were considered to have gastrointestinal bleeding secondary to benign gastric ulcers. One was admitted to the surgical service and one to the medical service. Both patients underwent upper gastrointestinal series, were seen in consultation by a gastroenterologist, and were endoscoped. No surgery was performed in this group and both patients had an uncomplicated hospital course.

*Varices:* Nine patients were admitted to the hospital on thirteen occasions during the year for major upper gastrointestinal bleeding attributed to esophago-gastric varices. Seven of these patients were admitted initially to the medical service and two to the surgical service. Six of the nine patients underwent barium meal evaluation and five of the nine underwent endoscopic examination. Five of the patients underwent surgery (portocaval decompression procedures). Four of the nine patients with varices died during their hospitalization; two

patients post-operatively; and two who were managed by conservative measures (44 per cent mortality).

*Acute Erosive Gastritis:* Six patients were diagnosed as having major upper gastrointestinal bleeding, secondary to acute erosive gastritis. Four of these were considered to have gastritis etiologically related to salicylate ingestion, one patient in association with pancreatitis and one patient secondary to uremia. An upper gastrointestinal series was performed in five of these six patients and endoscopic examination in four of the six patients. Two patients underwent emergency surgery for control of persistent and massive bleeding. None of these six patients died during his hospital stay.

*Malignancy:* One patient with leiomyosarcoma of the stomach was admitted with major upper gastrointestinal bleeding. The patient had endoscopic and radiologic examination. No surgery or mortality was encountered in this small group.

*Stress Ulcer:* Acute stress ulceration was considered to be the source of bleeding in four



patients. One of these patients developed stress ulceration following right hemicolectomy, one patient following intracerebral hemorrhage, one following orthopedic surgery for hip fracture, and one was a post-cholecystectomy. None of these had endoscopic examination and only one of these patients underwent upper gastrointestinal series. Two patients were explored for diagnosis and therapy. Two of the four patients with stress ulcers died during their hospitalization—one treated operatively, one treated conservatively. Two patients were seen in consultation by members of the surgical staff; none was seen in consultation by a gastroenterologist.

*Upper Gastrointestinal Bleeding, Cause Unknown:* Six patients were signed out with this diagnosis. Five of these were initially admitted into the medical service and one to the surgical service. Four of these had upper gastrointestinal series and two underwent endoscopic examination. None of these patients had selective celiac angiography. None of these patients underwent surgical exploration. Two of the patients died during their hospital stay (33 per cent mortality). Post mortem examination was not obtained in either of these cases.

### Analysis According to Diagnostic Procedures

(A) *Endoscopic Examination:* Of the fifty-four patients admitted to the hospital on sixty occasions, only sixteen patients underwent endoscopic examination. These procedures were performed at any time from the first to the twenty-ninth day after admission. The average interval between the clinical cessation of bleeding and endoscopic examination was three days.

Five of the nine patients with varices, four of six patients with gastritis, and both patients with gastric ulcer disease were examined by this technic. Only two of the patients with peptic ulcer disease, two of the patients with upper gastrointestinal bleeding of unknown cause and none of the patients with stress ulcer were endoscoped.

Endoscopy also varied significantly according to the primary physician (admitting service) and the major consultant. Of the sixteen endoscopic examinations, thirteen were done while the patient was on the medical service and only three when the patient was on the surgical service. When a surgeon was the only or major consultant (sixteen cases), endoscopy was performed only once. When a gastroenterologist was the only or major consultant (seventeen cases), endoscopic examination was performed nine times.

(B) *X-Ray Studies:* Forty-five of the fifty-four patients received an upper gastrointestinal series during the sixty hospital admissions. This was the most common diagnostic procedure used in patients with major upper gastrointestinal bleeding. On twelve occasions, upper gastrointestinal series was not performed. Seven of these twelve patients had no other diagnostic procedures during their hospital admission and will be discussed below as a separate group. Of the remaining five patients who had no upper gastrointestinal series during their hospital admission, three underwent endoscopic examination at which time the diagnosis of esophageal varices was made. The remaining two patients underwent surgical exploration with a post-operative diagnosis of acute stress ulceration. Selective celiac angiography was not used in any of the patients included in the study.

(C) *Combined Endoscopy and Upper Gastrointestinal Series:* Only nine patients were examined with both endoscopy and upper gastrointestinal series during sixty hospitalizations for major upper gastrointestinal bleeding.

(D) *Surgery as a Diagnostic Procedure:* Of the nineteen patients who underwent surgery, only two were explored for primarily diagnostic reasons, having had no other pre-operative diagnostic studies. Both of these were patients with acute stress ulceration. One of these two patients died post-operatively.

(E) *Patients Who Had No Diagnostic Pro-*

*cedures:* It is of interest that seven patients admitted to the hospital with major upper gastrointestinal bleeding had no diagnostic procedures. Four of these seven patients died during their hospital stay (57 per cent mortality). Two of the seven who had no diagnostic procedures were considered to be suffering from upper gastrointestinal bleeding of unknown cause or site. Both died and no postmortem examinations were obtained. Three patients who had no diagnostic procedures were considered to be bleeding from esophagogastric varices. One patient died and esophageal varices with fresh bleeding was noted at post-mortem; one patient with known chronic liver disease and varices from previous radiologic studies had recurrent upper gastrointestinal bleeding and was admitted to the hospital on three occasions during the year; and one patient with known chronic liver disease had esophageal varices detected on a subsequent admission early in 1971. One patient had upper gastrointestinal bleeding attributed to gastritis secondary to uremia and one patient was considered to have upper gastrointestinal bleeding secondary to stress ulceration following right hemicolectomy.

## Comment

There are two basic approaches to the diagnosis of major upper gastrointestinal bleeding problems. In one, all patients admitted with this diagnosis undergo early endoscopic and radiologic examinations. This aggressive philosophy has been termed the "vigorous diagnostic approach."<sup>1</sup> The aim of this approach is early, accurate, and objective detection of the bleeding site, resulting in more effective and rational therapy. The positive advantages of this active diagnostic effort have been well amplified for both medical and surgical management.<sup>1, 2, 3</sup> Diagnostic pitfalls based on errors of assumption in relying on limited and/or indirect diagnostic technics can be minimized. This vigorous diagnostic philosophy has given rise to the additional concept of a "team approach"—to include a medical and surgical physician, a skilled endoscopist, and an available radiologist.

The alternate diagnostic approach is more conservative, limited, and variable. In this situation, the frequency, type, and order of diagnostic studies is dependent upon the individual physician's doctrine and the specific problems of the patient. Individualization of diagnostic effort is stressed in this philosophy. In both cases, sound clinical judgment and consultative skills are utilized.

The present study indicates that major upper gastrointestinal bleeding is a common and serious medical and surgical problem at Hackensack Hospital. Fifty-four patients fulfilled the criteria for inclusion in the study and accounted for sixty admissions during the twelve month period. One out of three of these patients required major surgery and one out of six patients died during their hospital stay. The over-all mortality of 16 per cent is high as compared to other series dealing with major upper gastrointestinal bleeding.<sup>4, 5, 6</sup> It is also a significant mortality figure when compared to the 20 per cent mortality figure for acute myocardial infarction patients at Hackensack Hospital during the same time period.<sup>7</sup>

The composition of the patients included in this study, their causes of bleeding, and the distribution between medical and surgical services is similar to other series<sup>4, 5</sup> dealing with this problem. The average number of units transfused is high (ten per patient). Average age of the patients in the mortality group is interestingly lower than the average age of the entire group.

A review of the diagnostic procedures used in the present study clearly indicates a limited and variable approach. Endoscopic examination was performed only sixteen times during sixty hospital admissions, and combined endoscopy-radiology only nine times. Upper gastrointestinal series was the most common diagnostic procedure used. The demonstration of a lesion on roentgen examination was usually sufficient to implicate this as the actual bleeding site, without endoscopic confirmation. In no case was the patient considered to be bleeding from more than one site. Seven patients admitted to the hospital with major up-

per gastrointestinal bleeding, had no diagnostic procedures. The mortality of this group was 57 per cent. Twelve per cent of the patients were discharged with unknown bleeding sites. Selective celiac angiography was not used in any of the patients included in this study.

When compared to the studies in which a vigorous diagnostic approach was used, certain additional differences are noted.<sup>2, 3, 4</sup> The present series has a higher incidence of peptic ulcer disease (46 per cent) and a lower incidence of erosive gastritis (12 per cent). No diagnosis of erosive esophagitis or Mallory-Weiss syndrome was reported. This may well reflect the emphasis on radiology rather than endoscopy as a prime diagnostic procedure.

The selective aspect of diagnostic procedures in the present series is revealed in a greater use of endoscopy for patients with bleeding attributed to varices, gastritis, and gastric ulcer. This was not uniformly performed in all suspected cases, however. No patient with peptic ulcer disease and aspirin ingestion was endoscoped nor were any of the patients with stress ulceration. Only two of six patients with gastrointestinal bleeding of unknown cause were endoscoped.

It is of interest that endoscopic examination varied as much with the philosophy of the primary physician and major consultant as with the patient's disease process. Despite a relatively proportional distribution of patients between the medical and surgical services, the use of endoscopic examination in the bleeding patient was significantly less on the surgical service or with a surgeon as the primary consultant.

Since the team approach to gastrointestinal bleeding is a natural development of the vigorous diagnostic concept, the present study likewise reflects a limited use of this approach. Although consultation was employed

in many cases, fewer than half of the patients had one consultant (either surgical or gastroenterologic) and less than one in eight patients had two consultants.

## Conclusion

Major upper gastrointestinal bleeding is a common and serious medical and surgical problem at Hackensack Hospital. A review of the diagnostic procedures and approach to this problem indicates a very limited use of early endoscopy in combination with radiology. Selective celiac angiography was not used at all, despite its known value and availability. Lesions demonstrated on barium examination were frequently assumed to represent the actual bleeding site without endoscopic confirmation. This resulted in a higher incidence of peptic ulcer disease and a lower incidence of mucosal bleeding lesions as compared with other studies. Six patients (12 per cent) were considered to be bleeding from an unknown site; although the diagnostic studies in the sub-group could not be considered complete. Seven patients admitted to the hospital with major upper gastrointestinal bleeding had no diagnostic procedures.

It is quite possible that greater use of the vigorous diagnostic and team approach in the evaluation of patients with major upper gastrointestinal bleeding will result in earlier and more accurate diagnosis. This may well result in more effective and rational therapy.

## Bibliography

1. Palmer, E. D.: *Upper Gastrointestinal Bleeding*. Springfield, Illinois, Charles C. Thomas, (1970)
2. Palmer, E. D.: *JAMA*, 207:1477 (1969)
3. Gordon, E. H.; *et al.*: *Ann Int Med*, 71:993 (1969)
4. Katz, D. *et al.*: *JAMA*, 188:405 (1964)
5. Walls, W.D., *et al.*: *Lancet*, 2:7721 (1971)
6. Schiller, *et al.*: *British Med J*, 2:7 (1970)
7. Wiener, M., Coronary Care Unit, Hackensack Hospital. Personal Communication

15 Anderson Street





# Nose clear all knight

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

**Dimetapp  
Extentabs®**

Dimetane® (brompheniramine maleate), 12 mg, phenylephrine HCl, 15 mg, phenylpropanolamine HCl, 15 mg

**INDICATIONS:** Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

**CONTRAINDICATIONS:** Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma.

Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

**WARNINGS:** *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

**PRECAUTIONS:** Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

**ADVERSE REACTIONS:** Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

**HOW SUPPLIED:** Light blue Extentabs in bottles of 100 and 500.

**A-H-ROBINS**

A. H. Robins Company  
Richmond, Va. 23220



**for  
today's  
pain...**

**memory of  
yesterday's  
pain...**

**apprehension over  
tomorrow's  
pain—**




For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain. Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides  $\frac{1}{4}$  grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

**the analgesic formula that calms instead of caffeinates**

## Phenaphen<sup>®</sup> with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital ( $\frac{1}{4}$  gr.), 16.2 mg. (warning: may be habit forming); Aspirin ( $2\frac{1}{2}$  gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate,  $\frac{1}{4}$  gr. (No. 2),  $\frac{1}{2}$  gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

**Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

 Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Virginia



*"Sorry, Sire, but  
'Dicarbosil' hasn't  
been invented yet."*



## Dicarbosil<sup>®</sup>

ANTACID

**Write for Clinical Samples**  
**ARCH LABORATORIES**  
319 South Fourth Street, St. Louis, Missouri 63102





**Ampicillin, Carbenicillin, Oxacillin...**

# IMAGINE YOUR PRACTICE WITHOUT THEM

In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

Need we say more?

Prescribe the discoverer's brands:

**Totacillin<sup>®</sup>** (ampicillin trihydrate)

**Pyopen<sup>®</sup>** (disodium carbenicillin)

**Bactocill<sup>®</sup>** (sodium oxacillin)

and more to come

**Beecham-Massengill  
Pharmaceuticals **BMP****

Div. of Beecham Inc. Bristol, Tennessee 37620

- ☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.
- ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
- ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

# Severe Depression Resembling Severe Physical Illness\*

**Arnaldo Apolito, M.D./Montclair**

Depression seems to be on the rise among people of all ages. It can be mild, but is often severe enough to be called psychotic depression. This can lead to death. The pathological changes that depression can bring into the body through biochemical and neuroendocrine mechanisms are still poorly understood, but they can cause serious organic illness.<sup>1</sup> The state of illness that can derive from the inability or refusal of the depressed patient to take food and drink, to move his bowels, to get out of bed, can easily be understood. Finally there is the danger of suicide, the incidence of which is highest among depressed patients. It is a syndrome which often goes undiagnosed for a long period of time. Some are never diagnosed. This is due not so much to the incompetence or negligence of the physician as it is to the variable symptomatology of depression. One used to hear frequently in the past about organic illnesses (especially organic brain syndromes) being diagnosed and treated as emotional disorders, but unfortunately the opposite seems to occur much more frequently when it comes to depression.

We usually think of depression as a state of more or less profound sadness, with agitation or psychomotor retardation, with guilt feelings either experienced consciously or implied in delusions and hallucinations, with suicidal ruminations, and so on. But this classical roster of symptoms may not be present. Some severe cases of manic-depressive psychosis known as "depressive stupors"<sup>2</sup> or of involutional melancholias, the so-called "cata-

tonic phenomena"<sup>3</sup> may be difficult to distinguish from schizophrenia. The diagnostic problem becomes much more difficult in cases of "Depression sine Depression," which are much more frequent than one may believe. Some authors<sup>4</sup> state that they represent ten per cent, others up to thirty per cent of all depressions. Depression is hidden by hypochondriacal and/or psychosomatic symptoms. Classical symptomatology of depression may become apparent at a later date or it may never appear. Some of these patients have undergone medical or surgical procedures, some have been placed in nursing homes or hospitalized in state mental institutions for indefinite periods of time. They are believed to be suffering from a chronic physical illness or from severe arteriosclerotic or senile brain syndromes.

A depression may be superimposed on an organic illness or may be "primary." The secondary type is observed more frequently in diseases of the central nervous system, especially in arteriosclerotic and senile conditions. Two factors seem to have major etiologic importance. These are a premorbid personality with a disposition toward depression which is aggravated by the realization on the part of the patient that he has impaired brain function and a breakdown of psychological defenses due to such an impairment. These depressions always aggravate the symptoms of the organic illness<sup>5</sup> and are often masked by the

\*Read before the section on Psychiatry and Neurology, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 7, 1972. Dr. Apolito is Assistant Clinical Professor of Psychiatry, CMDNJ at Newark.



latter. Such incidences are so frequent that if one assumes and looks for depression in all these disorders, he will seldom go wrong. These conditions can be tremendously ameliorated with supportive psychotherapy aided by the psychotropic drugs. A postencephalitic man, who apparently had become very depressed when he realized that his memory had become very poor, was hospitalized in a state of seeming severe dementia. After he had been in the hospital for a few days, he became much more alert, talkative, and conscious of his state. He said that his memory was very bad and he had been unable to do the things he used to do before the illness, "but," he added, "when one gets into me I can remember much better." He was saying that when people took some interest in him, he came out of his dejection and withdrawal and his brain functioned better.

Masked depressions of the "primary" type can occur at any age from childhood on. They seem to be more frequent in childhood and middle age and to be more severe than in other stages of life. We are going to focus on some syndromes which I have observed in women past the age of menopause and so theoretically past the age of the so-called involuntional psychoses.

*Case One*—A 59-year old woman was brought to my office because of severe confusion, disorientation, loss of concentration, and an almost total memory loss of four months' duration. She had also developed a delusion that her single brother, who lived nearby, was having a love affair with a young girl. The patient had been heard talking to imaginary people and had been seen pursuing some kind of a shadow in the house. She had been seen by another psychiatrist, who had diagnosed her as suffering from early senility and the condition was considered hopeless.

The patient's facial expression was wan. She paid no attention to me and talked to herself incessantly. Her thinking was completely incoherent and showed a great deal of perseveration. Emotionally she was very bland and exhibited no symptoms of depression. The possibility of an organic brain syndrome seemed quite strong. However, a detailed history taken from a close family member revealed that this patient had had emotional problems for many years, which had culminated in a frank episode of depression fifteen years previously. She was a self-effacing, dependent, and rigid woman. She had been married twice, both times to worthless men whom she had had to divorce. Following the end of both her marriages she had gone back to her mother. The latter became ill and the patient took care of her for a whole year before she died. Following her mother's death she became quite

jovial and ambitious. This took place two years before the present illness. I decided to treat this patient for depression. She was 59 years old, had history of depression, and of a hypomanic episode following her mother's death, and I did not feel like pronouncing a sentence of doom as the other physician had done.

She was placed on Thioridazine® and amitriptyline. Within one week she showed a dramatic change. Contact with her became possible. She explained that she had felt bothered when she had seen her brother talking to a young girl from the neighborhood more than once. She was jealous. She informed me that she was very lonely. She visited her brother only occasionally, but as long as he had no other attachments, she felt a certain security in him.

After a few weeks the patient had improved very markedly and she was no longer delusional or hallucinating. I still see her occasionally. She has maintained her improvement. She has never complained of depression, but says that she feels tired, apathetic, and listless. These are signs of depression. She has exhibited no gross signs of organic brain disease after three and one-half years from the onset of this episode.

*Case Two*—A 62-year old married female was admitted as an emergency into the local hospital because of a syncope. When first seen, she was confused and disoriented. Thinking was incoherent and delusional. She believed that she was the Virgin Mary and that she was incurably ill. Her mood was one of depression. She had long been a religious, puritanical, and retiring person. She had achieved a profession but she had practiced it very little. She didn't seem to have much confidence in herself. Then, shortly before this illness, she had found out that her husband was involved with another woman. She had continued to live as though nothing had happened but she had been overtly anxious for several months and had been treated with tranquilizers. Her condition had worsened and, for several days, she had exhibited some jerky movements of her right limbs.

In the hospital, her gait was very unstable and she appeared very weak. Physical examination was essentially negative. She was put to bed and psychotropic medications were prescribed. Two days after admission this patient became aphasic, extremely lethargic, incontinent of feces and urine, and had to be tube fed. The suspicion of a metastasis from a previously excised epithelioma became strong. Such a suspicion was confirmed by the neurologic consultant who did spinal fluid, vascular, and air studies of the brain. The outcome was negative and the diagnostic status remained quite uncertain. I decided at this point to inject 500 milligrams of sodium amytal into her vein. She opened her eyes, asked for water and pleaded that the gastric tube be removed. She was asked why she had refused to respond for about one week. Her reply was that she was very despondent and she did not want to be bothered. This patient eventually recovered to reach her premorbid state and showed no signs of organic brain impairment.

*Case Three*—A 54-year old married female was seen in the emergency room of a hospital because she was acutely ill. She looked weak and haggard. She was very nauseous, her thinking was slow and tentative. Her concentration was very poor. Her husband informed me of her fear that their daughter had taken off that day to never come back home. Apparently, she had been nauseous and anorexic for about one month following an injection of an anesthetic for tic dolooureux. At the hospital she had a temperature of



101.6 and a pulse of 135. Physical examination was negative, except for a sinus tachycardia and myocardial ischemia. Albumin in the urine was 2+, BUN and SGOT were elevated.

During the last ten years she had been taking care of her old mother and one single brother, all living in the same house, besides taking care of her immediate family. However she insisted this had put no strain on her. Menstrual periods had ceased four years ago.

The vagueness of the physical symptomatology and a general attitude of dejection made us think of a depressive syndrome, even though she denied feeling depressed. Treatment with antibiotics and psychotropic medications was started. Temperature continued elevated for six days and then it subsided for four days. On the tenth day it spiked again, this time with pain to the left side of the chest. Radiologic evidence suggested bronchopneumonia. Later a pleural effusion was found. When this resolved, an area of pulmonary infarction was revealed. By this time the patient's pulse reached 150 per minute. She was digitalized and given antibiotics and electrolytes intravenously. Hyperthyroidism was suspected. Originally an elevated T<sub>3</sub> was found and the patient was given thiouracils. She improved and the thyroid function and all other tests became normal. Her pulse was still between 105 and 110 upon discharge.

When she was seen at the office she appeared frankly depressed and very tense. She again denied any feeling of depression. She was polite and thankful for the help received, but she remained evasive and grossly uncommunicative. She was composed and offered few complaints, but her pulse was still 110. After five months of treatment she finally told me that on the first day I saw her she was convinced that her daughter had left home and that her husband was going to have her (the patient) arrested for a reason unknown to her. She was kept on psychotropic medications and was seen for supportive psychotherapy. She eventually improved remarkably. Her pulse slowed down to 100.

To recapitulate, the first patient presented a clinical picture which resembled Pick's or Alzheimer's diseases. The second strongly suggested an intracranial mass. The third was, for some time, suspected to be a case of systemic infectious disease. Actually in the third case a systemic disease ultimately did appear, apparently secondary to an electrolyte imbalance and a circulatory insufficiency. A detailed and careful history, combined with the awareness of the frequency of depression can help to make a prompt diagnosis.

It is difficult to classify these depressions both clinically and etiologically. Some cases could be grouped among the manic-depressive, some among the involutional psychoses, but they have an additional and different flavor in their clinical picture. This makes one suspect that some organic factors play a role in the pathogenesis and symptomatology of the

illness. These patients had not become psychotic at the time of their menopause, but became ill at a time of their life which represents somewhat of a gray area between the menopausal and the arteriosclerotic-presenile age. We know that arteriosclerotic changes in the brain take place quite early in life, even though they remain grossly asymptomatic. It is very possible then that organic changes, similar to but less severe than the ones found in frank arteriosclerotic and senile psychoses, cause a breakdown within a precarious system of emotional defenses and so precipitate the psychosis. The psychologic factors however predominate by far. Unfortunately the dynamics of depression are far from being systematized. Freud's contention that depression represents a reaction to the loss of a love object<sup>7</sup> is still widely accepted. The three patients I have described cared only to talk about their symptoms and it was not wise on the part of the therapist to probe too deeply into their psyches. Therefore, a theory based on unconscious conflicts can hardly be proved or disproved from the material that they supplied. However, the theme of loss was present in all three cases. The first patient had lost her mother two years previously and she had been dreaming about her every night since then. Later on she became afraid that she was losing her brother's affection. It was then that she became ill. The second patient faced the possibility of losing her husband to another woman. The third woman who had the delusion that her young daughter had left and that her husband was going to have her arrested offered some interesting speculations. She was considerably older than her husband and therefore she must have been concerned with old age. The meaning of her delusion seems to have been that her own youth was abandoning her and for that reason her husband was going to have her put away.

Other authors point to a trait of "resignation" often observed in persons who tend to become depressed. This trait means that their main strategy to deal with life is avoidance of conflict. When such a strategy fails, depression ensues.<sup>8</sup> Rubins<sup>9</sup> attempted a psychodynamic formulation that encompasses all

forms of depression. He emphasized the meaning of self-hate and self-contempt caused by hurt pride. This leads to lowered self-esteem and to depression as a direct consequence. He further suggests that the symptomatology of depression may vary according to personal, cultural, and physiologic factors without constituting different nosological entities.

In our cases we have described three women who were predominantly "resigned." Their tendency to comply without complaining or rebelling in order to avoid struggle is quite clear. This was their defensive system which functioned well until environmental, psychological, and physiological circumstances rendered it inoperative. The organic or physiological component of the syndromes colored and distorted the clinical picture of classical depression. The personality make-up of these patients did not permit them, even at this point, to openly express their conflict and to cry for help. By becoming ill in this way they expressed their psychological predicament

through the psychosomatic route. So the somatic component becomes not only a cause, but also a means through which these people attempt to communicate with the world around them.

## Bibliography

1. Enelow, A. J.: *Depression in Medical Practice*. Rahway, Merck, Sharp and Dohme, (1971)
2. Arieti, S.: *American Handbook of Psychiatry*, Vol. I. New York, Basic Books, (1959)
3. Strecker, E. A.: *Fundamentals of Psychiatry*. Philadelphia, Lippincott, (1942)
4. Lesse, S.: *American Journal of Psychiatry*, 124:35 (May 1968)
5. Enelow, A. J., *op. cit.*
6. Spitz, R. A. and Wolf, K. M.: *Psychoanaly. Study of the Child*, 2:313 (1946)
7. Freud, S.: *Mourning and Melancholia*, Collected Papers, Vol. 4. London, Hogart Press and the Institute of Psychoanalysis (1953)
8. Symonds, M.: *American Journal of Psychoanalysis*, 28:189 (1968)
9. Rubins, J.: *Am. Journal of Psychoanalysis*, 28:139 (1968)

80 Undercliff Road

## NIMH Publishes Aging Study

An HEW study of the biologic and behavior changes of age indicates the aged demonstrate "great reserves of energy, intellect, and enthusiasm" in adapting to circumstances. The book is called *Human Aging II: An Eleven-Year Followup Biomedical and Behavioral Study*. Prepared by HEW's National Institute of Mental Health, it analyzes survival among healthy elderly men, and considers medical and psychiatric aspects and social adaptation of the aging.

The NIMH began to explore and define normal human aging in 1955 with the study of a group of healthy male subjects with an average age of 71. Results of that initial investigation were discussed in 1963 in the volume

*Human Aging: A Biological and Behavioral Study*. This second volume contains data on the long-term effects of aging on biologic and behavioral functions and clarifies the interrelationships among these functions with respect to the aging. The report relates physical and behavioral factors to later developments in old age, survival, or death. It describes how both physically healthy and unhealthy individuals adapt to aging and discusses how the aged view themselves and the environment.

Copies of *Human Aging II* (HSM) 71-9037—\$1.25 and *Human Aging* (HSM) 71-9051—\$2.50 are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

# THE COLD RUSH OF '72

Meet it with **Cerose®** for coughs of colds



*Exempt Narcotic*

**CEROSE®** for relief of coughs due to colds, whenever an antitussive formulation having sedative, decongestant, antihistaminic, and expectorant actions is required

Each 5-cc. teaspoonful contains: codeine phosphate, 10.0 mg. (*Warning:* May be habit forming); phenindamine tartrate, 10.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, grape-flavored base, alcohol 2½%

*Non-narcotic*

**CEROSE-DM®** for relief of coughs due to colds. It diminishes the cough reflex, promotes expectoration, and provides effective vasoconstriction and bronchodilatation. Contains non-narcotic dextromethorphan

Each 5-cc. teaspoonful contains: dextromethorphan hydrobromide, 10.0 mg.; phenindamine tartrate, 5.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, mixed fruit-flavored base, alcohol 2½%



*Exempt Narcotic*

**CETRO-CIROSE®** for relief of simple coughs where a plain sedative-expectorant is required. An excellent vehicle for many other commonly employed adjunctive cough medications, as preferred by the physician

Each 5-cc. teaspoonful contains: codeine phosphate, 5.0 mg. (*Warning:* May be habit forming); fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, cherry-flavored base, alcohol 1½%

**IVES LABORATORIES INC.**

New York, N.Y. 10017



DEDICATED TO IMPROVING THE QUALITY OF LIFE, THROUGH MEDICINE



# YOU CAN MAKE A DIFFERENCE



Overcrowding, unemployment, discrimination and hunger contribute to mental illness. They also serve as barriers between the poor and proper diagnosis and effective treatment of mental illness.

The National Association for Mental Health is committed to tackling the problems of the disadvantaged, by helping them secure the benefits of advances in the prevention, diagnosis and treatment of health problems.

Your Mental Health Association is working to ensure that services for the mentally ill are provided in areas where they are needed the most.



## JOIN AND SUPPORT YOUR MENTAL HEALTH ASSOCIATION

*Citizens Who DO Make A Difference*

Automation carries on. Here is a device which, Dr. Safir suggests, can be operated by paraprofessionals.

# Future Technics of Refraction\*

Aran Safir, M.D./New Rochelle, N. Y.

Modern electronic and optical technology have made possible the construction of an instrument which can automatically perform an important part of refraction. Refraction tests by paramedical technicians can relieve skilled practitioners of a significant, time-consuming burden. In this way, a new technic of refraction may serve as a model, helping to demonstrate how modern developments in technology can affect the practice of medicine and the delivery of health care services. This may permit the medical profession to extend its skills and services to many who (through poverty, ignorance, or isolation from medical facilities) fail to receive the kind of eye care that the medical profession ought to be able to assure every person in this country today.

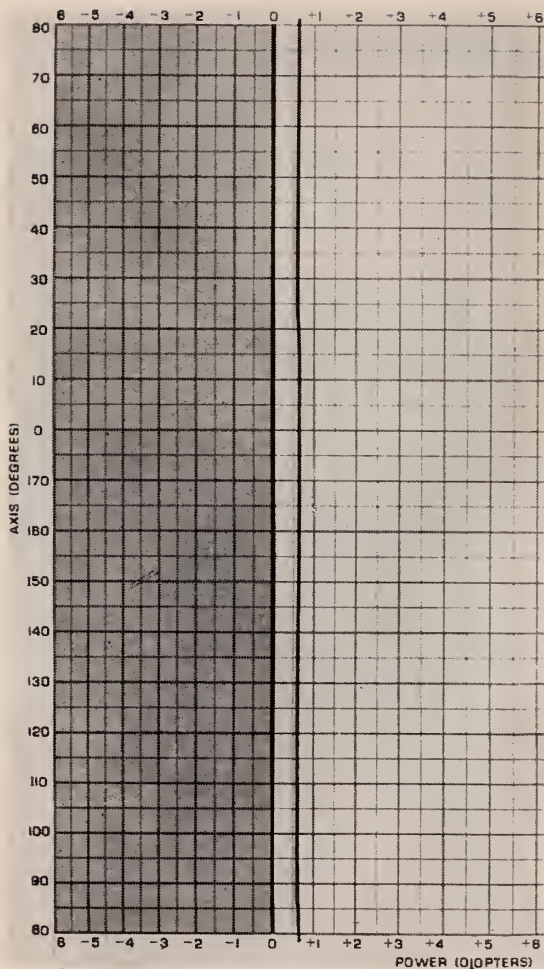
The instrument, the *Ophthalmetron*, operates on the principle of retinoscopy,<sup>1</sup> a technic used by nearly all ophthalmologists. This involves the projection onto the subject's retina of a small patch of illumination. Some of the light is reflected from the retina and emerges through the subject's pupil, acted on by the optical elements of his eye. The rays will emerge from the subject's eye either convergent, parallel, or divergent depending on whether the eye is myopic, emmetropic, or hyperopic. The skilled practitioner causes the spot of light to move around on the patient's retina and, depending on the movement he sees of the light emerging from the patient's pupil, he decides what refractive error the patient has. He measures it by placing in front of the patient's eye corrective lenses to neutralize the refractive error of the eye. The *Ophthalmetron*<sup>2</sup> is designed to be operated by a person who need not have any skill in or knowledge of refraction. The instrument is



Figure 1—Technician aligning the *Ophthalmetron* in preparation for measuring the subject's refractive error. The subject is seated at the right and has her gaze directed at a color photograph of a rocket blasting off. The technician, using the operator's eyepiece, sees a bulls-eye target superimposed on the image of the patient's eye. With her right hand she is operating the joy stick control and the concentric ring at its base which elevates or lowers the *Ophthalmetron*. When the alignment is complete the operator will press the "operate" button which is seen just to the right of her right hand.

self-contained and mounted on top of an ordinary optical instrument table. The subject is seated at it with his chin in a chin rest and forehead against a forehead rest, very much as if he were seated at a slit lamp. (See Figure 1). The operator inserts a sheet of record paper into the machine and positions the instrument approximately in front of one eye of the subject so that the subject sees a color photograph which makes it easy for him to hold his gaze steady. The operator looks through an eye piece and sees a bull's-eye type of target projected onto the image of the subject's pupil. With a simple "joy stick" control the operator brings the instrument into fine

\* Read before the Section on Ophthalmology, 206th Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 7, 1972. Dr. Safir is Associate Professor of Ophthalmology at Mt. Sinai School of Medicine, New York.



(Graphs have been abbreviated in figs. 2 and 3 for publication, but Ophthalmetron can measure to 20.50 diopters of myopia and 17.50 diopters of hyperopia.)

Figure 2—Tracing from the *Ophthalmetron*. Along the abscissa are listed the dioptric values of the spectacle correction necessary for the eye under study. The heavy vertical line at zero signifies the position of the emmetropic eye. Myopic corrections are to the left and hyperopic to the right. Along the ordinate are listed the meridians in ordinary ophthalmic nomenclature. This tracing is from a subject with a small degree of hyperopia. The line drawn by the pen in the *Ophthalmetron* shows that the subject is measured as having a hyperopia of just above 0.50 diopters. The slight fluctuations in the line are due to small changes in the subject's state of accommodation during the three seconds required for the measurement.

alignment exactly in front of the patient's eye. This procedure requires twenty to thirty seconds. When the alignment is complete, the operator presses a button marked "operate" and the *Ophthalmetron* performs its measurement in a period of three seconds. The operator can then remove from the machine a writ-

ten record of the patient's refractive error giving the prescription of the lens to correct the optical defects of that eye. (See Figures 2 and 3).

Clinical trials<sup>2, 3</sup> show that the *Ophthalmetron* performs objective measurements of the refractive error of the human eye in both adults and children, with or without cycloplegic drops, with about the same degree of reliability as a skilled refractionist. We have trained a number of people as operators of the *Oph-*

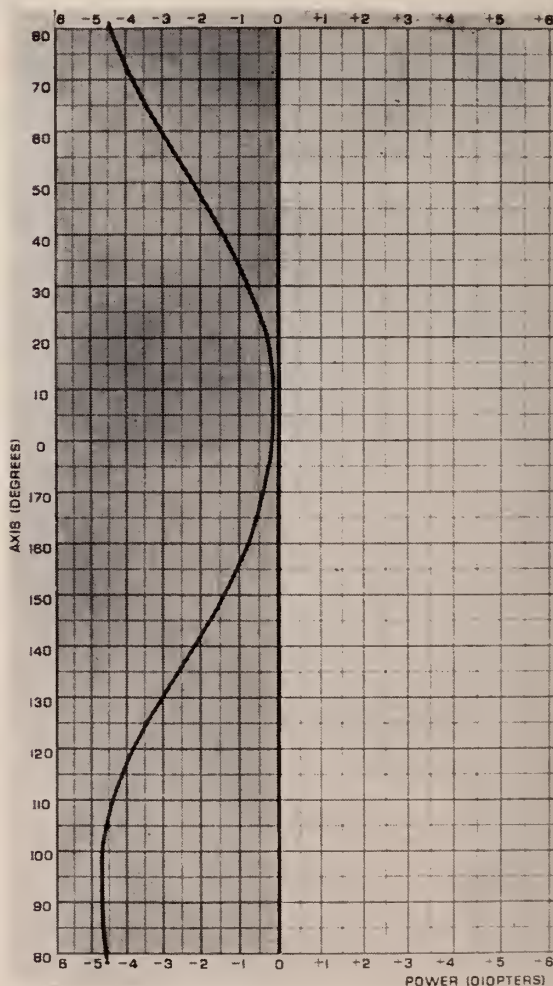


Figure 3—*Ophthalmetron* tracing from a subject with a large myopic astigmatism. The most myopic meridian (the furthest leftward excursion of the tracing) is at  $-4.75$  diopters. The least myopic meridian is at approximately  $-0.25$  diopters. The interval between these two extreme points on the curve is 4.50 diopters. This is equal to the amount of astigmatism present. Either plus cylinder or minus cylinder notation may be used in writing this. This could be written as  $-4.75 +4.50 \times 95^\circ$ , or, in minus cylinder form, as  $-0.25 -4.50 \times 5^\circ$ .



*thalmetron*. These have included skilled laboratory technicians who were accustomed to operating a variety of laboratory instruments, nurses who had never worked in ophthalmic nursing, and people who had no technical education and had not completed high school.

We recently completed the screening of a number of children in an East Harlem grade school in New York City. In this school the Department of Community Medicine at Mount Sinai School of Medicine had developed a program of selecting and training neighborhood women as school health assistants. These women acted as aids to the school nurse. They had assisted in the ordinary school health screening programs, helped visiting physicians with blood testing, accompanied patients to hospital clinics, and performed other duties not requiring knowledge of the eye or refraction. Several of these women became expert operators of the *Ophthalmetron*.

One purpose of this project, was to determine whether we could separate the school children into a few important groups:

1. Children without strabismus, with normal visual acuity, and with trivial refractive errors.
2. Children with poor visual acuity based on a simple refractive error only. This group would be identified by the fact that trial eyeglasses made up from lenses prescribed by the *Ophthalmetron* would restore the subject's acuity to normal. These children would receive eyeglasses but would need no further referral.
3. Children with defective visual acuity which could not be brought up to normal by the use of eyeglasses. These children would be diagnosed by the *Ophthalmetron* as having refractive error but their vision would not respond to the application of trial eyeglasses. These children might have organic disease of the eye rather than simple refractive error, and would be referred to an ophthalmologist.

We trained the paramedical assistants to perform all the tests and their results were compared to the results obtained by a panel of ophthalmologists who examined all the children examined by the technicians. The agreement between the two groups was excellent. It was our conclusion that it is entirely feasible both technically and economically to train and employ paramedical technicians to screen school children, to perform refractions on them, prescribe suitable eyeglasses for them

when needed, and identify those children needing further care.

It is now possible to perform refractions on large numbers of children without the use of skilled practitioners except for supervision and referral. This means that the community, if it wishes to devote the appropriate resources to this goal, could arrange for all children to be screened at regular intervals so that we could be confident that our school children had vision adequate to the tasks given them. The need for such programs of identification of sensory deficiencies is well known. It is possible that such a large scale program might make a significant improvement in the results of our educational system. Large numbers of children may be doing badly in school because they have serious handicaps in either vision or hearing or both.

Few conditions adversely affect visual acuity in school-age children. The tragic tumors and glaucomas of infancy are rare and usually identified before the school years. Not until after the grade school years do other diseases begin to occur with frequencies that are statistically important.

When we talk of screening adults we are confronted by a more difficult problem because glaucoma becomes common enough to be looked for in mass screening programs. The addition of glaucoma screening methods to the screening technics for refractive error just described for school children would permit technicians in a health maintenance organization to refer to ophthalmologists only those patients with a very high likelihood of having organic disease. This would be a great boon to the ophthalmologist associated with such screening programs, for it has been one of the weaknesses of mass screening that the lack of specificity of the screening technic has referred large numbers of relatively normal patients to practitioners whose time would be better spent with patients more likely to have disease.

What is the prospect for automatic refraction changing the practice of ophthalmology? Most

American ophthalmologists are solo practitioners, although there is an increasing tendency toward practice in partnerships or small groups. Nearly every patient who comes to an ophthalmologist must be refracted because the commonest cause of visual disability is a refractive error. Nearly always we start our examination by performing retinoscopy. We make our objective estimate of the refractive error and then enlist the aid of the patient with various subjective methods, calling upon him to make responses so that we may alter or refine the findings from retinoscopy. The final prescription for the proper correcting lens for that eye will depend very much on the skill of the practitioner with the retinoscope and the ability of the patient to make fine discriminations with subjective testing.

There are no accurate figures on how long it takes a practitioner to perform retinoscopy. Time studies lead us to believe that the average practitioner spends about 90 seconds performing retinoscopy on the average eye. To be on the safe side we will say that a practitioner spends a minute an eye doing retinoscopy. This means that he spends two minutes with each patient performing this repetitive mechanical task that requires considerable skill and concentration. It is not unusual for a successful and busy practitioner of ophthalmology to see in his private office 20 to 30 patients a day. Spending two minutes per patient in retinoscopy means that a practitioner of ophthalmology may very well spend about an hour a day slavishly performing retinoscopy. He must have good refractions if he is to know whether the patient can see normally. Only when he knows that the patient cannot see normally, in spite of a clearly focused retinal image, can he be fairly confident that there is something wrong in the visual system further back than the refractive system.

An *Ophthalmetron* may not be particularly valuable to a practitioner who functions with no technical assistant in his office. If he is skillful with the retinoscope, he can obtain nearly the same results in nearly the same amount of time, using the traditional method. Why bother with an automatic refracting instrument unless it gives results superior to those he could obtain by the traditional methods? We do not have enough clinical experience to know whether this is a correct point of view. In high degrees of refractive error (for example: patients after cataract surgery) where retinoscopy is often very difficult, the *Ophthalmetron* can obtain results better and faster than the practitioner. But in a busy practice it is unusual for an ophthalmologist to work without at least one and usually more than one technical assistant. Under these circumstances a much less skilled person might save the practitioner up to an hour a day of his time. This would permit him to spend more time doing those difficult tests that only a practitioner can perform or, just as importantly, to spend more time explaining to his patients the results of his diagnostic tests. Since refractive errors (with few exceptions) are not disease states but are merely statistical deviations from a more desirable norm, it may be desirable to introduce into practice an instrument and a method for relieving the practitioner of a repetitive mechanical chore which stands between him and the achievement of the goal for which he was trained—the detection and treatment of disease.

## References

1. Safir, A.: *Apparatus For Objectively Testing An Optical System*, U. S. Patent No. 3,136,839, accepted June 9, 1964.
2. Safir, A., Knoll, H. A., and Mohrman, R.: *Trans. Am. Acad. Ophth. and Otol.*, 74:1266 (Nov.-Dec., 1970)
3. Knoll, H. A., Mohrman, R., and Maier, W. L.: *Amer. J. Optom.*, 47:644 August, 1970)

69 Highridge Road

*This is something we all talk about, but will we do anything about it?*

# Disaster Planning Can Save Lives\*

---

**William A. Dwyer, M.D./Paterson**

During September, 1970, the northern counties of New Jersey were twice subjected to severe flash flooding. Several lives were lost in each. The press and the public at large referred to these events as "disasters."

*Disaster* is defined as a sudden and extraordinary misfortune. It implies an unforeseen mischance bringing with it the destruction of life or property.

These popularly dubbed "disasters" result in a truly impressive annual loss of life—one hurricane has caused the loss of hundreds of lives; major area flooding is also associated with large losses of life; the loss of life on our highways was in excess of 53,000 people last year.

As medical men concerned with the preservation of life and the causes for the loss of it, it would seem worthwhile to question the public assumption of the inevitability of these events and their grisly aftermath. Anyone who has watched or listened to weather reports on TV or radio knows that hurricanes are predicted at least one and sometimes several days in advance. A reasonably accurate flood forecasting service is in operation. The effects of blizzards on the population are well documented. Natural phenomena are not really unforeseeable; rather they are in large part predictable and are being predicted. The missing element is an inability to develop community response to these warnings. There is no way to translate these warnings into concrete action that has meaning

for the population in terms of preventing damage and saving lives. This is because no one at a local, county, or state level recognizes that anything can be done with these situations except to clean up the resulting mess.

There are, of course, unexpected happenings—industrial fires and explosions, plane crashes, and the like. The exact site of these happenings cannot be foretold, but no one can doubt that somewhere, some time a large industrial explosion will occur and somewhere, some time a plane will crash. These events will generate casualties and the survivors will require care. The fact is predictable as is the likelihood of an incident occurring in a particular locale. For instance, a plane crash is unlikely in Cape May, but the crash of a 747 jet at Newark Airport is a very real possibility.

Local jurisdictions choose to be ignorant of the potential for tragic events in their community. Knowledge of such potential would require some expenditure of time, thought, and possibly money. As long as the attitude prevails that nothing can be done about them anyway, the communities are content to deal only with the aftermath.

But, with a small amount of effort, a great deal can be done to mitigate the loss of life and the numbers of casualties resulting from both natural and man-made disasters. A couple of examples may suffice to illustrate this point:

\* From the Department of Surgery, St. Joseph's Hospital, Paterson, New Jersey.



*Case One:* In September, 1967, hurricane Beulah struck the Texas coast after a "long period of warning." This warning period allowed time for extensive evacuation of coastal areas and helped to keep casualties down. When it became obvious that the hurricane would hit their area, all the disaster medical directors met and reviewed the pre-planning that had been done. They also established a jury-rigged radio communications system, utilizing ham radio operators and the RACES program of the CD organization. However, loss of power and antennas as well as operator fatigue contributed to rather early failure of the system.

The winds themselves were destructive, but the major problem and source of most casualties was the resultant flooding that followed, exceeding anything ever experienced before in the area. Shortly after the hurricane struck all highways were impassable and one hospital was in danger of being flooded. Sixty hours after the hurricane, the highways were under 21 inches of water and all communications were out except for the police radio net. At this point, with the rain still falling, word was received of the need to provide for 12,000 refugees many of them old, sick, frightened, and without food or water. Utilizing the state's flexible disaster plan for its natural disaster capability, the local press was able to obtain help and medical supplies within eight hours *via* air transport and by trucks capable of fording the flood waters. These suppliers came from pre-positioned PDH (Packaged Disaster Hospitals) and ARDI (augmented pharmaceutical inventory programs) units. Medical teams from several surrounding areas were also brought in to help as was a USPHS team which proved invaluable because of its training in handling refugees. Most of the evacuation was provided by the National Guard.

In all, 2,000 patients were seen and treated. In the opinion of the authors of the article on this disaster, at least twenty fatalities, mostly infant dehydration, were prevented. But there were eight obstetrical cases, two

appendectomies, two gram-negative septicemias, and two vascular cases that were evacuated as well.

*Case Two:* During the civil disorder of 1968 in Washington, D.C., a small group of physicians had voluntarily organized themselves for just such an event. They rendered care to the population in the involved areas and to the prisoners. Their findings of diabetics unable to get insulin, epileptics without access to Dilantin®, and cardiacs without access to diuretic and digitalis medication were illustrative of the suffering of the innocent victims in riot situations and the lack of official care for them. More importantly, their report is a documentation of organization and forethought paying off in the saving of lives.

Both cases illustrate the basic ingredients necessary to arouse community response: (1) Awareness of the existence of a potential danger, (2) Planning to cope with this potential, (3) Organization of the routine community forces available to both deal with the immediate aspects of the problem and to accept supplementation by auxiliary forces so that both groups work effectively in the emergency.

Awareness of local situations must be derived from those in the community. This can be accomplished by conducting a survey through the police and fire departments and members of the business community. One method advocated by the Public Health Service is the creation of an Advisory Council to the mayor of each big community. This council could well serve to pinpoint all the local industrial hazards and plan for the handling of such incidents as may occur. Naturally, it would be of great importance to have some knowledgeable physicians and representatives of the area hospitals on such councils so that the adequate initial treatment and transport of casualties is thoroughly considered. More than local consideration is necessary, however. There are many aspects of such planning which cannot possibly be covered by the talent available in most communities.

In planning for the effects of natural phenomena such as ice storms and hurricanes, the influence of the weather on the terrain can be critical. For a seashore community such as Atlantic City, the height of the tide in a storm can be of major importance. The force of the wind at 50 as compared with 70 knots is another vital element in planning of this sort. Meteorologic expertise must be available to these local planning groups.

Additionally, there must be planning for the supplementation of available local forces in the event of large scale tragedies. For instance, with the advent of the 717 jet, Newark Airport authorities started to explore the ways and means of handling the possible crash of such a giant aircraft with its large passenger load. This provisional planning indicated that should most of the passengers survive (and granting a normal in-patient load at the area hospitals) the use of every hospital in Newark and Elizabeth would be required together with supplementary use of the Jersey City Medical Center and possibly hospitals in the Oranges.

The ambulance transport of these victims would be an enormous logistic problem both from the standpoint of mobilization and from the standpoint of traffic control at the scene. This transport would be further complicated by the virtually complete inability to communicate *via* radio with these ambulances in order to control their movements.

What is necessary in such a catastrophe? A statewide plan is required which is adaptable

to any large scale situation. This plan should take note of, and overcome in these large scale disaster situations, the local boundaries which so often are an interference in effective management of these emergencies. Such planning can occur only at the state level. And the expertise, meteorologic, explosive, special equipment, and communications must also come from state level. Development of the coordination between local areas must also come from the state level through such planning.

There is an epidemic loose in our midst and it behooves the medical profession to recognize it before its toll grows too much larger. Unlike appendicitis or pneumonia, this waster of lives will not respond to the ministrations of a single physician but rather our united action to make the public aware that lives need not be lost in man-made or natural calamities. Rather, that with effective planning the situation can be contained by personnel briefed in their roles and a public whose awareness of the danger has been aroused.

Local planning is essential, but a statewide disaster plan is the skeleton on which the muscle of local planning can act.

## References

1. Davis, J. H., Thornton, J. J., and Weckesser, F. C.: *Journal of Trauma*, 5:16 (January, 1965)
2. Queen, C. R. and Stewart, R. S.: *Texas Medicine*, 63:124 (November, 1967)
3. Frank, Arthur, Roth, Jesse, *et al.*: *New England Journal of Medicine*, 280:247 (January 30, 1969)

412 Park Avenue

## SCIENTIFIC EXHIBITS

MSNJ members are invited to participate in the Scientific Exhibits at the 207th Annual Meeting, May 12-15, 1973. For information and application, see page 971 this issue, or communicate with Mrs. Marion Walton, MSNJ Convention Manager, P.O. Box 904, Frenon 08605.

# THE MEDICAL SOCIETY OF NEW JERSEY

## Endorsed Insurance Plans

### ACCIDENT AND HEALTH INSURANCE

- \$1,200** a month maximum BASIC total disability benefit.  
Accident: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
- ↓
- PLUS** Sickness: from 8th day, up to 2 years  
Accident: may be EXTENDED to Lifetime  
Sickness: may be EXTENDED to 7 years
- ↓
- \$1,000** a month maximum NEW LONG-TERM PLAN.  
Payable up to Lifetime for accident—Age 65 for sickness  
Choice of waiting periods:  
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

★ ★ ★

### LIFE INSURANCE

- \$10,000 to \$150,000** of Convertible Term Life Insurance  
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)
- \$10,000 to \$50,000** of Convertible Term Life Insurance  
available for spouse, dependent children and employees.

★ ★ ★

### MAJOR EXPENSE INSURANCE

- \$25,000** maximum for Covered Expenses as stated in the policy for each accident or sickness, covering member, spouse, and eligible children. \$750 deductible, 20% co-insurance. (Physicians' and surgeons' fees are not a Covered Expense.)

★ ★ ★

### HOSPITAL-MONEY PLAN

- \$20-\$30-\$40** per day paid for each day that you or your dependents are hospitalized, from the first day for as long as 365 days for any one accident or sickness. Benefits are tax-free.

★ ★ ★

### SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

- \$200,000** maximum for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance. \$100,000 maximum for spouse (without disability benefit).

★ ★ ★

H.R. 10 (KEOGH) RETIREMENT PLAN ★ ★ CORPORATE MASTER PLAN

#### APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected or have applied for membership.

*Information and claim service are as close as your telephone.*

**E. & W. BLANKSTEEN AGENCY, INC.**

75 MONTGOMERY STREET, JERSEY CITY, NEW JERSEY 07302

(201) DElaware 3.4340



## To Inherit and To Possess\*

Merlin K. DuVal, M.D., Washington, D.C.

I am grateful for the opportunity your invitation provides to get away from the frenetic and frustrating world of Washington and return—however briefly—to the academic world which has played such a major role in my life. I am a temporary expatriate from the campus and plan to return to the University of Arizona following my first-hand look at the medical world from within the federal government.

When I was asked last year to go to Washington and address the medical needs of a country instead of a college, some of my friends in the profession were no doubt reminded of the British professor who entered his laboratory one day and wrote on the blackboard these words: "Professor Wilson informs his students that he has this day been appointed honorary physician to His Majesty, King Edward." During the class period the professor was called from the room for a few minutes and on his return found these additional words written beneath the announcement: "God save the King."

And speaking of God, we in the medical profession would do well not to forget Benjamin Franklin's adage that "God heals . . . the doctor takes the fee."

Commencement addresses traditionally are ego-massaging exercises filled with praise for how far you have come; usually a reminder that to commence is merely to begin, and offering warm reassurance that the goal you have reached has been well worth the effort. Only occasionally do such addresses require much introspection on the part of their listeners.

Although I intend to depart from that formula, in the hope that my remarks might elicit

some serious self-analysis by both you who are graduating and your younger student-colleagues in the audience, first let me assure you that your hard-won degree is indeed worth all the sweat and trauma that it represents. I feel about the medical arts the way Samuel Johnson felt about his beloved London when he said, "Who does not love the City does not love life, for the City has all that life can afford." The medical profession, which you are officially entering today, does have all that life can afford.

Look deeply within yourselves for the answer to this question: Why do I want to practice the healing arts? What does this degree really represent to me: a ticket to the so-called "good life" lived in ease in some affluent suburb . . . or an opportunity to perform a vital service for my fellow man? Where is your commitment—to serving yourself or to serving others? We who have chosen medicine as a career have contracted peculiar debts as well as peculiar opportunities. Let me address myself to these debts and suggest some ways we might square them.

To whom are these "peculiar debts" owed? They are owed, first of all, to a venerated American public which has matched—and in many ways exceeded—the blessing every society showers upon its physicians. These debts are also owed to the Flemings, the Curies, the Listers, the Salks, and the other men and women of medical science whose pioneering work is our rich heritage. And they are owed to the many thousands of medical practitioners who have labored selflessly in every age to

\*Delivered at the graduation of the class of 1972 of the New Jersey Medical School, College of Medicine and Dentistry of New Jersey, Saturday, June 3, 1972, Newark, New Jersey. Dr. DuVal is Assistant Secretary for Health and Scientific Affairs, DHEW, Washington, D.C.

relieve the suffering of those who have lost the priceless commodity of good health.

In Goethe's epic legend, Faust, an old man, knows he is nearing the end of his mortal life. At one point, the scholar Faust surveys the knowledge represented by the books in his library, which he will never have the opportunity to absorb, and he contemplates the worldly experiences he will never have the opportunity to share. And then, in his exquisite anguish, Faust cries out this wisdom: "Before we can possess that which we have inherited from our fathers we must first earn it for ourselves."

Goethe, in this timeless lament, has summarized the one thought I hope to leave with you today. May I repeat it: "Before we can possess that which we have inherited from our fathers, we must first earn it for ourselves."

You are more fortunate than Faust. When he realized the difference between inheriting and possessing, he was at the end of his productive years. You are at the beginning of yours. Will you have the foresight to know that you, too, must earn for yourselves the esteem and honor that has been bestowed upon your medical forerunners? I sincerely hope so.

Faust was saved from his fate by selling his soul to Mephistopheles in exchange for additional time to pursue the mysteries of the universe and to taste life in the real world. The knowledge that was bought in the trade served Faust well—for in the end he had learned enough to trick Mephistopheles out of his reward.

The lesson of Faust teaches us the importance of planning our lives with care now so that when we, too, near the end we will not find ourselves in similar anguish over having been profligate with our time and talents. Unlike Faust, however, we must live a life and not a legend. If we pledge our souls unworthily, no amount of knowledge or trickery will reclaim them in the end.

All of which brings us to the question of how

we can make a contribution in the field of medicine that is indeed worthy of both our heritage and our potential as individual doctors.

Although our system of health care in the United States is the best the world has ever seen, it abounds with paradoxes. These paradoxes are mirrored in the attitudes of our fellow citizens, too many of whom view physicians as greedy Mr. Hydes rather than as benevolent Dr. Jekylls. A large segment of our society is seriously preoccupied with good health and fearful of the consequences of losing it.

Last year, a private research group commissioned the Gallup organization to conduct interviews with representative cross sections of the American population to identify their greatest hopes and their greatest fears. Leading the list of personal hopes was that of good health for one's self. Leading the list of personal fears was that of ill health for one's self. Both of these concerns, incidentally, were more personally important to the interviewees than such things as a better standard of living or even peace in the world.

Let me enumerate some of the paradoxes that contribute to these concerns:

We have reduced our infant mortality rate more than 75 per cent since 1900. But in a nation that prides itself on being number one in so many fields of human endeavor, we rank behind 13 countries which have lower rates. Even worse—infant mortality in America is nearly twice as high for blacks and other minority groups as it is for whites. Just being born black in our country shortens one's life expectancy by six or seven years . . . and the health of Indians and Alaska natives is almost a generation behind that of other Americans.

In 1950, our nation had about 149 physicians for every 100,000 persons and (heaven forbid) many of them even made house calls! Today we have about 162 physicians for the same number of people. Despite this increase of 13

physicians for every 100,000 citizens, however, there is a growing deficiency in the supply of doctors and other health professionals, and in some inner-city and rural areas of the country the deficiency today is critical.

Ironically, our inability to provide adequate health care to all parts of the nation is, in no small measure, due to the continuing improvement in the education and training of our physicians. In 1929, only about one-fourth of the nation's physicians were specialists. By last year, more than three-fourths were actively engaged in one of the specialties. The family doctor—who is the primary provider of family care—accounted for only 17 per cent of all physicians. As a result of increased specialization, we actually have 5,000 fewer family doctors than we had in 1957.

Compounding the problem is the fact that not very many new physicians are setting up practice where they are needed most—in poor urban areas and in rural sections of the country. In some cities, there are more doctors in a single professional building than in an entire urban ghetto. In the nation's capital, for example, three years ago the virtually all-black Anacostia section had 67 doctors' offices for a population of 217,000. Across town in Washington, a primarily white neighborhood had five times as many doctors serving a population less than half as large as Anacostia's.

Rural areas face similar problems, and today in the countryside we have 132 counties with a combined population of 472,000 without a single physician. It doesn't take much imagination to understand why studies of comparable injuries show people dying in rural accidents more often at the scene of the accident, dying sooner after injury, and dying of less serious injuries than those hurt in urban accidents.

The paradox of the nation's health care system can also be told in terms of dollars and cents. In 1950, Americans paid about \$78 each for medical care. In 1971 they paid nearly five times that much, yet many of them had con-

siderably less access to adequate medical and dental service.

The spending of greater and greater sums of money—reaching an incredible \$75 billion last year—regrettably has not netted us anywhere near a corresponding increase in health services for our citizens. In fact, while national health expenditures have increased nearly 200 per cent since 1960, more than half of the increase has gone to meet price inflation, and not to provide better care—or even more care—at all!

The public's impatience at our inability to get a handle on these costs (and to translate our nation's great material wealth into better health care for all our people) is swiftly reaching flash point. Little wonder that the pressures are becoming intense for the federal government to take an increasingly large role in our nation's health care delivery system. In fact, in many ways the relationship between the American medical community and the government is at a crossroads today. The turn it will take can be very significantly affected by your response, and that of the other 1972 graduates of our nation's 108 medical schools, to the needs that have been outlined here.

I readily confess that neither I, nor anyone else at HEW, has the answers to the questions I have raised this morning. On the contrary, Secretary Elliott Richardson—who, incidentally, comes from a distinguished family of physicians himself—and I share Learned Hand's profound belief that "the spirit of liberty is the spirit which is not too sure that it is right." And we both serve an Administration which believes in the wisdom of the many, not the few; which believes in the spirit and the substance of self-determination; and which is convinced that the insights of those on the firing line of American medical training and practice are the *sine qua non* of the solution.

In facing the challenge we cannot—any of us—be as cavalier as one young intern who was said to have been recently in a large metropolitan hospital. A waiter in a restau-



rant down the street was suddenly stricken with an illness and rushed to the hospital's emergency room. Lying on an emergency room operating table in great pain while awaiting attention, he saw our intern passing by. "Doc," he said desperately, "I'm sick. Can't you do something?"

"Sorry," the intern replied. "This isn't my table."

Let me repeat. Even though the American system of health care has tremendous assets, it too is in pain. And, believe me, the table it is on belongs to all of us.

The role of the government, as we at HEW see it, is to provide the leadership and the tools to permit the rest of the health family to undertake its tasks with increased effectiveness. One indication of the leadership we have taken to meet health and other human needs is that the budget we have proposed for the next fiscal year exactly reverses the major budget priorities of just five years ago. In 1968, the defense share of the budget was 45 per cent; the human resources share was 32 per cent. In 1973, the human resources share of the budget will be 45 per cent and the defense share 32 per cent.

The federal government has also provided some important new tools for you to pick up and use. One of the most promising of these is the National Health Service Corps, created in 1970 as one answer to the critical shortage of health manpower in the inner-city and the countryside.

Under the program, a physician can devote two years of his or her life, at a salary guaranteed by the government, working where he or she is needed most. In addition to the obvious benefit of having the government stand the expense while you establish a private practice, there is also in it for you the satisfaction of knowing that your idealism and youthful energy will be enshrined forever in the hearts of the men, women, and children who are waiting desperately for your help. Some of you might also be interested to know that service

in the National Health Service Corps is one way of fulfilling your military obligation—although the Corps itself is otherwise totally unrelated to military service.

Incidentally, an additional 150 physicians will be joining the Corps next month—making it possible for us to expand our services from the 20 communities we now serve, to an additional 100 communities.

There are, of course, other ways to be of exceptional service if you have the will to do so. You might, for example, go to Dade County, Florida, and seek out Luis Garcia who is 9 years old but is the size of a 7-year-old. Luis has never owned a toothbrush or a comb. He has never been examined by a doctor or a dentist. Luis, who shares a bed with two other brothers in a shack which has no plumbing, belongs to one of the more than one million migrant families who harvest the nation's fruit and vegetable crop each year. You *can* help the Luis Garcias, you know. One way would be to work at HEW's Migrant Health Program which has established a network of 130 local health centers where migrants now have access to regular health care.

Or you might consider joining HEW's Indian Health Service. If you did, you could end up working on the Navajo Indian Reservation, which includes a big chunk of my own state, as well as parts of three other states, and has over 100,000 of our first Americans living on it. On the other hand, you could go to the Supai Village on the floor of the Grand Canyon. This village can be reached only on foot or horseback, or in emergencies by helicopter. The health needs of the 300 Havasupai Indians who live in the village are currently met by a community health medic trained by the Indian Health Service. A physician visits the village only once a month.

To students of every profession, the transition from the classroom and the laboratory to where the action really is can be a letdown, and sometimes even a comedown. If this happens to be your lot, be assured that you're in good company. The great Albert Schweitzer,

who held doctoral degrees in music, philosophy, and theology, as well as medicine, related that in 1925, as he began to rebuild the hospital at Lambarene that the jungle had reclaimed during the war, he was desperately short of manpower, and began to haul beams and planks himself. Then he saw an African in a white suit sitting by a patient he had come to visit. "Hello, friend—won't you lend us a hand?" asked Dr. Schweitzer. "Sorry, I am an intellectual and don't drag wood," was the answer. Dr. Schweitzer shrugged and replied, "You're lucky. I too wanted to become an intellectual but I didn't succeed!"

And so, as you receive your degree today, I hope you realize not only how much we appreciate your perseverance and the sacrifice you have made to achieve this distinction, but that you also realize that your diploma is only a part of the key to the world of medical practice, and that it is now up to you to unlock that world by dedicating yourself to help those who need and trust you and are waiting for you. And may we as doctors remember: "Before we can possess that which we have inherited from our fathers—we must first earn it for ourselves."

---

### Emergency Medical Identification

The Medical Society of New Jersey in cooperation with the USPHS has been conducting a program to inform citizens of the necessity for emergency medical identification. Accidents on the highway, in the home, at work, and at playgrounds number in the millions. Accidents may become more complex by a lack of information concerning the individual's own medical needs or problem.

New Jersey is the most densely populated and urbanized state in the nation. It is imperative that individuals who harbor chronic illnesses be identified so that authorities rendering immediate medical aid be alerted.

The Emergency Medical Identification Symbol tells anyone rendering emergency care to a person who is unconscious or unable to communicate, that the bearer has a physical condition requiring special attention. Thus, diabetic coma sometimes makes it victims appear intoxicated and treatment may be dangerously delayed. The symbol is used to indicate allergies to antibiotics, such as penicillin.

The need for certain medicines must be known. Heart patients taking drugs to pre-

vent thrombi may bleed profusely if injured unless they receive special care. Epileptics could be saved much trouble and unnecessary hospitalization if they carried a card indicating they may have seizures. The emergency medical identification card could carry information such as name, address, whom to notify if ill or injured, the name of the doctor, and dates of immunization, particularly against tetanus. Special problems would also be noted on the card.

The Special Committee on Emergency Medical Care has solicited the support of more than 640 agencies within government, public affairs, and private industry and has received endorsements of the program and cooperative assurances. Requests for EMI posters, wallet cards, and leaflets have exceeded initial estimates. The program is moving rapidly in the schools throughout New Jersey and various organizations are distributing EMI items to their memberships and featuring the program in their respective publications. The Division of Emergency Health Services, USPHS, has provided EMI posters, wallet cards, and symbol leaflets in substantial numbers for distribution in the campaign.

ALSO AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

## Android<sup>®</sup> 5

MUQUETS  
BUCCAL Tabs

Methyltestosterone N.F. - 5 mg.

## Android<sup>®</sup> 10

Methyltestosterone N.F. - 10 mg.

## Android<sup>®</sup> 25

Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4,3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating male for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSE AND ADMINISTRATION:** Dosage must be strictly individualized as patients vary widely in requirements. Daily requirements are based on administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg
Postpubertal cryptorchidism	30 mg

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

**BROWN**

THE BROWN PHARMACEUTICAL CO., INC.  
2500 West 6th Street, Los Angeles, California 90057



---

# NEW JERSEY DOCTORS' NOTEBOOK

---

## Trustees' Minutes

September 17, 1972

A regular meeting of the Board of Trustees was held on September 17, 1972, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

*Carrier Clinic Symposium . . .* Concurred in the action of the Executive Director in granting the use of MSNJ's name as a cooperating agency in the Carrier Clinic's forthcoming seminar on psychotherapeutic drugs to be held on October 4.

*Jersey City Medical Center's Application Under Emergency Health Personnel Act of 1970 . . .* Agreed to support the endorsement by the Hudson County Medical Society of the Jersey City Medical Center's application for the assignment of corps personnel in the Medical Center's emergency room.

*Award for Contribution to Handicapped Workers . . .* Directed that the name of Jarvis M. Smith, M.D., Medical Director of the New Jersey Rehabilitation Commission, be submitted in nomination for the 1972 Physician's Award which is presented (upon recommendation of the President's Committee on Employment of the Handicapped) to the physician who has made the most outstanding contribution to the employment of handicapped workers.

*Regional Health Insurance Council Conference . . .* Agreed that MSNJ should be officially represented at the meeting of the Health Insurance Council on October 12 and 13 in Hershey, Pennsylvania. The President was empowered to name one or two representatives (expenses will be paid).

*AMA Meeting of Legal Counsels . . .* Authorized the Assistant Executive Director to at-

tend the Clinical Convention in Cincinnati and represent MSNJ at the workshop for legal counsels to be held during the convention, November 26 to 29.

*Physician Intermediaries in Adoptions . . .* Approved the following recommendation (which resulted from consideration of a communication from the New Jersey Conference of Catholic Charities expressing concern of the role of physicians, acting as intermediaries in adoption placements) from Legal Counsel:

That the law quoted below be included in the "Legal Obligations Affecting Medical Practitioners" insert of the Membership Directory, and that the Membership Newsletter make appropriate mention of this subject and related law.

**2A:96-6** Placing or assisting in placing child for purpose of adoption without proper authority

No person, firm, corporation, association or agency shall place, offer to place, or in any manner assist in the placement of a child in the home of any other person, or persons for the purpose of adoption, other than in the home of a brother, sister, aunt, uncle, grandparent or step-parent of such child, unless such persons, firm, corporation, association, or agency shall be the natural or adopting parent of the child, or shall have been approved for such purpose as provided by law. Any person, firm, corporation, association or agency violating this section shall be guilty of a misdemeanor.

**2A:96-7** Placing of children for adoption; other than by approved agency for consideration forbidden; exception

No person, including a natural parent or parent by adoption, and no firm, corporation, association or agency, other than an agency approved to place children for adoption as provided by law, shall place, offer to place, or in any manner assist in the placement of a child in the home of any other person or persons for the purpose of adoption and, in so doing, take, receive, or pay any money or anything of value, or undertake or discharge any financial obligation, except in connection with the birth and any illness of the child. Any person, including a natural parent or parent by adoption, and any firm, corporation, association or agency, other than an agency approved to place children for adoption as provided by law, violating this section, shall be guilty of a high misdemeanor.

The purpose of the law quoted above was to prohibit all placements, other than with close relatives, by any person or agency not approved for that purpose by the Department of Institutions and Agencies and not in accordance with laws governing the adoption of children (R.S. 9:3-17 et seq.). Adherence to the above quoted and cited laws will prevent trafficking for profit in human lives and eliminate the so-called "black market" in babies.

*Pediatric Nurse Practitioner . . .* Instructed Legal Counsel to prepare a reply to Christian M. Hansen, Jr., M.D., of Rutgers Medical School, indicating that MSNJ was of the opinion that the proposed pilot pediatric nurse practitioner program is fundamentally sound but that it should be stipulated that in all cases the pediatric nurse practitioner is to work under the authority and direction of the physician who is legally and professionally responsible for the patient's care. It was directed that the New Jersey Chapter of the American Academy of Pediatrics be requested to supply its opinion of the proposed program.

*Note:* This pilot program was developed jointly by Rutgers Medical School and Rutgers University College of Nursing. It is concerned with the establishment of a program to utilize better the professional nurse as a source of manpower in the delivery of primary health care to children and their families. The 16-week, full-time study course will include clinical practice; this is followed by once-a-week seminars for six months. Upon completion the pediatric nurse will be able to obtain and critically evaluate medical histories, perform physical examination, discriminate between normal and abnormal variations, know when to refer the child to a physician, manage minor common childhood conditions in collaboration with a physician, carry out immunization plans, provide counseling to parents, and coordinate services for total care of child and family.

*M.D. Personnel, Inc. . . .* Concurred in the action of the Executive Committee to grant official approval to the sending of a letter from Louis Douglas, Vice-President of M.D. Personnel, Inc., to licensed physicians in the New Jersey-New York area offering to place physicians in various specialties who are seeking employment in a hospital or facility within their specialties. The function of M.D. Personnel, Inc. (whose services are paid for by the hospital or facility) is that of an intermediary; the physician and the hospital or facility enter into a mutual agreement for services.

*Conference of Liaison Committees Between Medicine and Nursing . . .* Directed that MSNJ representation at the Conference of Liaison Committees Between Medicine and Nursing, November 9 and 10 in Itasca, Illinois, be at the discretion of the President; expenses will be paid should a MSNJ representative attend.

*Associate Membership . . .* Directed that a proposed amendment(s) to eliminate the category of associate membership as presently constituted be transmitted in writing to the Secretary of the Society to initiate the process set forth under the requirements for amendments to the Constitution and Bylaws.

*Conference on Continuing Education . . .* Concurred in the action of the Executive Committee in inviting William T. Snagg, M.D. to represent MSNJ at the Greater Delaware Valley Regional Medical Program Conference on Continuing Education, October 19 at King of Prussia, Pennsylvania.

*AMA Regional Seminar on Aging . . .* Concurred in the Executive Committee directive that Matthew E. Boylan, M.D. be designated as MSNJ's representative at the AMA regional seminar for administrators and medical directors of long-term care facilities, to be held at White Plains, New York in October.

*Health Professions Master Plan . . .* Accepted an invitation from the Department of Higher Education to provide speakers on "The Role of the Physician in the United States to 1985" and on "Team Concept: A practicing Physician's Viewpoint" at separate hearings to discuss the preliminary draft of the Master Plan for Health Professions Education. Arthur Bernstein, M.D. will speak on the first topic and Henry J. Mineur, M.D., will represent MSNJ on the latter.

*Emergency Cardiac Care . . .* Approved the following amended recommendation from the Committee on Emergency Medical Care:

That MSNJ approve the organization of pilot projects of pre-hospital cardiac care, embodying the use of drugs for emergency treatment under medical supervision and defibrillation by trained ambulance personnel.

*Emergency Medicine Departments at Medical Schools . . .* Tabled the following recommendation from the Committee on Emergency Medical Care.

That the hospital emergency department be recognized as a separate department equal to any other major department of the hospital; and further that this de-

partment be headed by a qualified physician director who will be of equal status with any other director of any major department of the hospital.

*Stenographic Coverage for JEMPAC Meetings . . .* Voted to go on record as supporting JEMPAC and to make available, at a reasonable rate, facilities and clerical assistance, including stenographic coverage for meetings, noting that advance notice of such facilities and services is required.

*MSP Complaints on Fees . . .* Directed that the President of MSP, Joseph P. Donnelly, M.D. (also legal counsel and such other staff personnel as he chooses) be invited to attend the next meeting of the Board to discuss justification of the Plan's sending letters to individual physicians alleging they were billing for additional services above the fees being accepted by their peers for similar services under the Prevailing Fee Program.

---

## Martland Names New Administrator

On September 1, Florence Gaynor took charge of Martland Hospital. She became the first black woman in U.S. history to head such an institution, serving as the primary health care facility for a medical school.

According to Dr. Harold A. Kaminetzky of the medical school: "It's not enough to be a skilled health administrator; what is required is a deep sensitivity for the human aspects of our profession and empathy for our patients.

In accepting the appointment, Mrs. Gaynor said, "This is indeed a challenging and exciting endeavor for me. Having previously lived in Newark, I am sensitive to its problems and to its new spirit of revitalization. I can sense a turning around in the care given at Martland and that the New Jersey Medical School has in the past few years made real progress in the upgrading of its staff, equipment, and facilities. The school's initiation of training programs to help Newark residents achieve new jobs in health care delivery means that Martland Hospital and the community will be working together in the future as partners sharing a common goal."

Mrs. Gaynor has been executive director of Sydenham Hospital, a 207-bed community hospital in New York City, for the past 18

months. From 1966 until 1971, she was associated with Lincoln Hospital in the Bronx, where she advanced from pediatric nursing coordinator at Albert Einstein College of Medicine to assistant hospital administrator, and then to associate executive director in charge of professional service, research, and training. At Lincoln Hospital, she was coordinator for the Health and Hospitals Corporation and for the hospital's renovation program. During her years there, she helped develop a pediatric home care program, served as training coordinator and coordinator of inpatient services, as well as on the faculty of Albert Einstein Medical College. Prior to that she coordinated a health education program which included case-finding for two schools. Earlier, she was head nurse supervisor at Frances Delafield Hospital in Manhattan, and was acting director of in-service education.

Mrs. Gaynor has been a consultant to St. Vincent's Hospital, Montclair, where she revised the curriculum and field work experience for the practical nurse program so that the nursing school could achieve accreditation. She has also served as consultant for a neighborhood maternity and infant care project and has been a steering committee member of the health careers' program at Lincoln Hospital.

She holds a diploma from Lincoln Hospital School of Nursing, a certificate in public health from the University of Oslo, a bache-



lor of science in nursing education, and a master of arts in public health administration. In addition, Mrs. Gaynor holds certificates in labor relations, management, curriculum planning, human relations, modern concepts of patient care, and data processing, and received a certificate in health systems management from Harvard University School of Business in July.

Mrs. Gaynor is a member of the Advisory Committee to Health, Education, and Welfare Secretary, Elliot L. Richardson, on Automated Personal Data Systems and a member of New York Governor Rockefeller's Committee on Physician Associates and Specialist Assistants. She has been a lecturer at Cornell University, the National League for Nursing—St. Vincent's Hospital, the Association of Nutritionists, and Downstate Medical College.

She is a member of the American Public Health Association, the League of Women Voters, and the International Youth Forum. She was named "Woman of the Year" by the Masons in 1971, and she is listed in *Who's Who in the East*.

## PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.*

**ANESTHESIOLOGY**—Celia Mencado Sagullo, M.D., 138 Terrace Place, Brooklyn, New York 11218. Manila 1963. Board eligible. Group or partnership. Available.

**CARDIOLOGY**—Paul Goldfinger, M.D., U.S. Navy Hospital, Department of Cardiology, Portsmouth, Virginia 23708. George Washington, 1966. Board certified (IM), Board eligible (C). Group, partnership, hospital. Available July 1973.

Richard H. Landesman, M.D., 477 Comstock Place, Highland Park, Illinois 60035. Vermont 1966. Board certified (IM). Group, partnership, hospital. Available July 1973.

**DERMATOLOGY**—Robert P. Feinstein, M.D., 9146 Springhill Lane, Greenbelt, Maryland 20770. NYU 1967. Board eligible. Group, partnership, solo. Available July 1973.

**FAMILY PRACTICE**—Biagio Scialpi, M.D., 156 Caryl Avenue, Yonkers, New York 10705. Bari (Italy) 1949. Group, associate, solo. Available.

Suresh C. Doshi, M.D., Box 212, Oceana Medical Center, Oceana, West Virginia 24870. Bombay (India) 1961. Partnership or other. Available July 1973.

**GASTROENTEROLOGY**—Kambiz Azmudeh, M.D. 6255 Broadway, Bronx, New York 10571. Tehran 1964. Board eligible. Group, or partnership. Available.

Ernest T. Bajpai, M.D., 250 Beverly Boulevard, Apt. F-105, Upper Darby, Pennsylvania 19082. Prince of Wales (India) 1955. Board eligible. Group or full-time salaried. Available July 1973.

Eugene F. Cheslock, M.D., 107 Beverwyck Drive, Gunderland, New York 12084. New Jersey Medical 1965. Subspecialty hematology. Board eligible. Group or hospital.

Cesar Soriano, Jr., M.D., 320 East Chestnut Street, Coatesville, Pennsylvania 19320. Santo Tomas (Philippines) 1965. Board eligible. Group, associate, partnership. Available.

**INTERNAL MEDICINE**—Noorollah Kashani, M.D., 107 New Street, East Orange 07017. Tehran 1966. Board eligible. Subspecialty gastroenterology. Association or partnership. Available.

Alfred M. Derrow, M.D., 16 Crawford Drive, Dix Hills, New York 11746. Tufts 1962. Subspecialty, nephrology. Board certified. Group or partnership. Available early 1973.

**NEUROLOGY**—Richard M. Sax, M.D., 3541 East Glencoe Street, Coconut Grove, Florida 33133. Louisville. 1968. Board eligible. Group or partnership. Available 1973.

**OBSTETRICS-GYNECOLOGY**—Charles J. Seigel, M.D., 217-10 Lexington Boulevard, Clark, New Jersey 07066. Pittsburgh 1967. Board eligible. Group or partnership. Available July 1973.

Jae-hak Choe, M.D., 481 8th Avenue, New York 10001. Kwangju (Korea) 1965. Board eligible. Associate, group, or partnership. Available July 1973.

Sangkyu Shin, M.D., 2502 Alter Road, Detroit, Michigan 48215. Yonsei (Korea) 1965. Group or associate. Available July 1973.

Mircea Veleanu, M.D., 9111 Church Avenue, Apt. 4-L, Brooklyn, New York 11236. Hadassah (Israel) 1964. Board eligible. Group or partnership. Available July 1973.

**ORTHOPEDICS**—Rother A. Bronfman, M.D., 8702 Pennsbury Place, Apt. 2, Richmond, Virginia 23229. New Jersey Medical 1966. Board eligible. Solo, partnership, group. Available July 1973.

Frank G. Guellich, M.D., Valley Forge Army Hospital, Phoenixville, Pennsylvania 19460. New Jersey Medical 1966. Board eligible. Solo or partnership (Mercer, Morris, or Somerset Counties). Available July 1973.

T. K. Kobayashi, M.D., 812 Woodside Drive, Iowa City, Iowa 52240. Colorado 1966. Board eligible. Group or partnership. Available July 1973.

Yeshawant V. Ginde, M.D., 149 Nighbert Avenue, Logan, West Virginia 25601. Bombay (India) 1961. Board eligible. Group, partnership, or hospital. Available January 1973.

OTOLARYNGOLOGY—George W. Hicks, M.D., 6139 Broadmoor Plaza, Indianapolis, Indiana 46208. St. Louis 1967. Board eligible. Group, partnership, association. Available July 1973.

Gary L. Townsend, M.D., 117 Nebraska Street, Dyess AFB, Abilene, Texas 79607. Yale 1966. Board certified. Solo. Available July 1973.

PATHOLOGY—E. Clifford Heinmiller, M.D., 1124 Washburn Place West, Saginaw, Michigan 48602. Iowa 1943. Board certified, AP and CP. Subspecialty computer science. Group for development of medical computer applications, medical records, diagnosis, etc. Available.

PEDIATRICS—N. Boramanand, M.D., 331 East 29th Street, Apt. 14-P, New York, New York 10016. Birmingham (England) 1965. Subspecialty, pediatric neurology. Board certified. Group, partnership, association. Available July 1973.

Barton W. Kaplan, M.D., P.O. Box 741, 4108 Hyde Park Drive, Chester, Virginia 23831. Upstate Medical Center (Syracuse) 1968. Special interest, developmental problems. Board eligible. Group, partnership, or association. Available July 1973.

J. S. Bharara, M.D., Monmouth Medical Center, Long Branch 07740. Amritsar (India) 1961. Board eligible. Group or partnership. Available.

K. Bhujanga Rao, M.D., 5501 North 11th Street, Apt. 404, Philadelphia, Pennsylvania 19141. DCH (India) 1961. Board eligible. Group. Available January 1973.

SURGERY—Michael J. Attkiss, M.D., 23 Hemlock Road, Newton, Massachusetts 01264. Columbia 1964. Group, partnership, solo, hospital, teaching. Available July 1973.

Nestor M. Sagullo, M.D., 138 Terrace Place, Brooklyn, New York 11218. Manila 1963. Board eligible. Solo or partnership. Available.

Mabini C. Piezas, M.D., 2401 Pennsylvania Avenue, Apt. 8-A-6, Philadelphia, Pennsylvania 19130. Southwestern (Philippines) 1961. Board eligible. Group or partnership. Available.

UROLOGY—Eugene J. Lind, M.D., 4B Collins Street, Westover Air Force Base, Massachusetts 01022. NYU 1966. Board eligible. Partnership or group. Available August 1973.

Franklin A. Morrow, M.D., 1 Wall Street, Fort Lee, New Jersey 07024. New York Medical 1966. Board eligible. Association or solo.

Bashiduddin N. Shaikh, Lockwood Clinic, 300 Bloor Street East, Toronto, Ontario, Canada. B. J. Medical (India) 1961. Board eligible. Group, partnership, solo. Available.

Marvin S. Wetter, M.D., 70-35 260th Street, Glen Oaks, New York 11004. Jefferson 1966. Group or partnership. Available July 1973.

J. G. Besai, M.D., 52 East Maple Street, Teaneck 07666. Bombay (India) 1958. Board eligible. Solo or association. Available.

## Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during September 1972:

	1972 September	1971 September
Aseptic meningitis	83	44
Primary encephalitis	3	1
Hepatitis: Total	262	491
Infectious	212	342
Serum	50	149
Malaria: Total	1	12
Military	0	9
Civilian	1	3
Meningococcal meningitis	0	2
Military	0	1
Civilian	0	1
Mumps	13	16
German measles	1	5
Measles	3	6
Salmonella	135	120
Shigella	28	56

## Measles and Rubella Immunization Program

Private physicians and public agencies in New Jersey have administered nearly one million doses of rubella vaccine to pre-pubertal children since 1969. This has markedly reduced morbidity among preschool and elementary school children, but recent surveillance of immunization levels and rubella morbidity has shown that in some areas of the state, half, or more, of the elementary school children, particularly those in grade 3 or above, may not be immunized. Outbreaks of rubella have been occurring in junior and senior high schools throughout the state in spite of relatively high levels of protection among children under 10 years of age.

Live virus measles vaccine has been around much longer (since 1963) and the percentages of susceptibles are smaller, but the picture is similar to that of rubella.

The State Health Department's immunization program plans to reduce future morbidity by protecting or accounting for all elementary school children, grades K through 6, with regard to measles and rubella immunity. The plan calls for systematic screening for histories of immunity followed by immunization clinics within the schools to protect the identified

susceptibles. Both measles and rubella vaccines will be used in the clinics.

At present, arrangements are in progress with county and local health and school officials in Sussex, Warren, Hudson, Gloucester, Cumberland, Essex, Camden, Passaic, Salem, Monmouth, and Burlington Counties for screening and immunization. It is hoped that activities in at least five counties will be completed before the first of the year. A continuation of the plan is projected through the 1973-74 school year.

## Medical College Notes

**Stanley S. Bergen, Jr., M.D.**  
**President CMDNJ**

Although the College of Medicine and Dentistry of New Jersey is one of the newest institutions of its kind in the country, it is growing quickly to meet the tremendous health care needs of our state. It was only two years ago, that the state legislature merged Rutgers Medical School with the medical/dental education complex of the New Jersey College of Medicine and Dentistry and thus created our college as a new entity.

We are four schools and two teaching hospitals: Graduate School of Biomedical Sciences, Newark; New Jersey Dental School, Jersey City; New Jersey Medical School, Newark; Rutgers Medical School, Piscataway; Martland Hospital, Newark; and Raritan Valley Hospital, Green Brook. Throughout our college complex, we employ over 3,300 people. We have a combined faculty of over 1,200, a student body of over 950 for 1972-73 and more than 1,400 alumni.

Enrollment at our four schools has grown from 718 in 1970 to 810 this past year. Of these, 227 were dental students, 25 graduate students, and 561 medical students. We continue to process many more applications from prospective students than we can hope to accept. In the past year, over 5,500 applicants competed for 287 openings at our schools.

With the development of our \$130 million Newark campus, the expansion of Rutgers Medical School, and the projected development of a third medical campus in the Camden area, we expect to graduate 320 to 360 physicians and 120 dentists each year by 1980.

Because of growing population and the expanding need for health care, there may never be sufficient physicians and dentists to handle the complete health requirements of all our citizens. For this reason, our college is actively committed to develop training programs in the allied health professions. The Career Ladder Training program, operated through the department of preventive medicine and community health at the New Jersey Medical School has already begun to train 60 disadvantaged Newark residents to fill a variety of health care jobs. So far, we have graduated 9 family health workers and plan to train 19 more. Ten students will soon enter a program for inhalation therapy technicians, and 20 will receive training as radiologic technicians. Five more students will study to be medical technologists. By July 1973, we expect to have a full complement of 60 trainees enrolled in the program and some 74 graduates working in the allied health field. Other programs, either developing or in the planning stage will ultimately lead to a full spectrum of educational opportunities in allied health.

Through Martland Hospital's Family Planning Program, we are training community workers in this aspect of health. The project has a "Youth In Action" section, which conducts programs at local high schools about venereal disease, a problem that has reached dangerous proportions in northern New Jersey. There is also a program for training licensed nurses to be family planning nurse specialists. Graduates of this 12-week course will lighten the physicians' load by performing pelvic and breast examinations, taking Pap smears, fitting diaphragms and intrauterine devices and selecting suitable oral contraceptives in addition to interviewing, counseling, teaching, and managing family planning programs.



At Rutgers Medical School, seven registered nurses are enrolled in a four-month program in conjunction with Rutgers University's College of Nursing which will prepare them as Pediatric Nurse Practitioners. Working in physicians' offices, they will assist in complete patient care, including such procedures as physical examinations, screening patients, administering inoculations and handling certain house calls. The expanded role of the Pediatric Nurse Practitioner will enable pediatricians to shift aspects of child care to these highly trained specialists, thereby providing the physician with more time for hospital-related activities and for increasing the number of office patient visits.

A Physicians' Assistant Program is developing at Rutgers Medical School in conjunction with Rutgers University's Livingston College. Working in the physician's office, these skilled allied health professionals will assist in diagnostic and therapeutic procedures, sometimes functioning independently.

At our College's New Jersey Dental School, we have also recognized the need for training allied health personnel. We have programs for dental assistants, dental hygienists, and expanded duty personnel who will be licensed to administer anesthesia and fill teeth under the supervision of dentists.

The expansion of facilities and growth in student body at our medical and dental schools, the development of allied health programs, the strengthening of our ties with community hospitals and other colleges throughout the state, our efforts to provide facilities needed for continuing professional education, and more, are all indices of the positive forward motion that is propelling our College into its needed role in the health care picture of New Jersey.

## Hospitals Must Furnish Free Care

The HEW Department has said hospitals funded under the Hill-Burton Act will be reviewed on a case-to-case basis to determine whether a "reasonable volume" of free care is furnished to persons unable to pay.

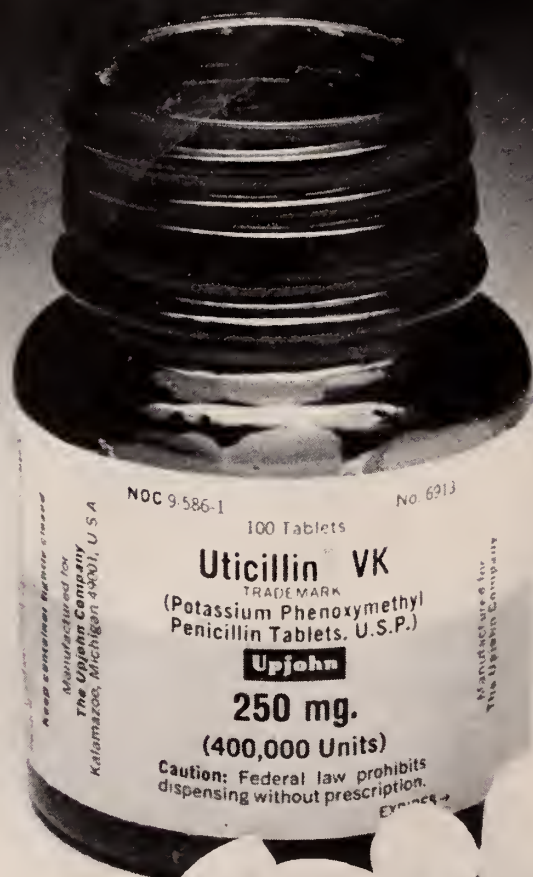
This interim regulation will enable hospitals already providing a large amount of free care to submit a report to that effect and be automatically in compliance. It also provides "presumptive compliance" levels of free care, which can be met in any one of three ways an institution chooses. In addition it sets guidelines for individualized determination for hospitals which are unable to meet the "presumptive compliance" levels.

In general, the new policy met objections of the American Hospital Association that the original proposals could put many hospitals out of business. HEW Secretary Elliot Richardson said the regulation, modified as recommended to him by the Federal Hospital Council, is being issued now in interim form so that some regulation is immediately in effect, in view of pending court cases.

Vernon E. Wilson, M.D., Administrator of the Health Services and Mental Health Administration, which directs the Hill-Burton program, said: "Much misunderstanding arose over the earlier version of this interim regulation published for comment back in April. Many people felt that the 'presumptive compliance' guidelines constituted standards to which hospitals would be held. It is important to understand that any institution which falls below the 'presumptive compliance' guidelines will have an individualized determination of what constitutes reasonable free care."

**Patronize Our Advertisers**  
**They Merit Your Support**

# Upjohn's low-priced penicillin VK



## Uticillin<sup>®</sup> VK

(potassium phenoxymethyl penicillin, U.S.P., Upjohn)

Available in 250 and 500 mg tablets;  
250 mg/5 ml and 125 mg/5 ml flavored granules  
for oral suspension

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2144-6

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of August 12, 1970: Section 3685, Title 39, United States Code)

1. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

2. Date of Filing: September 28, 1972.

3. Frequency of Issue: Monthly.

4. Location of Known Office of Publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the Headquarters or General Business Offices of the Publishers (Not Printers): 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor, and managing editor: Publisher, The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618. Editor, Henry A. Davidson, M.D., 315 West State St., Trenton, New Jersey 08618. Asst. Editor, Mrs. Marjorie Treptow, 315 West State St., Trenton, New Jersey 08618.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618 (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None (a non-profit corporation of New Jersey).

9. For optional completion by publishers mailing at the regular rates (Section 132,121, Postal Service Manual). 39 U. S. C. 3626 provide in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates authorized by 39 U. S. C. 3626. (Signed: R. H. Lambert, Business Manager, The Medical Society of New Jersey

10. For completion by non-profit organizations authorized to mail at special rates (Section 132,122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

11. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	8,906	8,900
8. Paid Circulation		
1. Sales through dealers and car- riers, street vendors and counter sales	—	—
2. Mail Subscriptions	8,471	8,470
C. Total Paid Circulation	8,471	8,470
D. Free Distribution by mail carrier or other means		
1. Samples, complimentary, and other free copies	326	332
2. Copies distributed to news agents, but not sold	—	—
E. Total Distribution (Sum of C and D)	8,797	8,802
F. Office use, left-over, unaccounted, spoiled after printing	109	98
G. Total (sum of E & F—should equal net press run shown in A)	8,906	8,900

R. H. Lambert, Business Manager,  
The Medical Society of New Jersey

The Scientific Exhibits — —  
207th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 207th Annual Meeting of this Society, May 12 to 15, 1973. Those interested in participating may use the application form on page 973. (Please complete both sides.) Remove the page from *The Journal* and mail directly to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

*Policy*—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

*Space* assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will not be ordered.



If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

*Application for space* in the Scientific Exhibit must be submitted no later than January 1, 1973, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to John J. Thompson, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton 08605.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 12, and close at 5 p.m., Monday, May 14. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 11, and all exhibits must be in place by 11 a.m., Saturday, May 12. Exhibits must remain intact until 5 p.m., Monday, May 14, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 15.

3. *Cost:* The Society provides free of charge such space exhibitor may require including booth with shelf, printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections*.

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent*. The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.

# THE MEDICAL SOCIETY OF NEW JERSEY

## 207th Annual Meeting

HADDON HALL

ATLANTIC CITY, NEW JERSEY

### APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 12-14, 1973

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

.....

.....

.....

.....

.....

3. Is the exhibit free-standing or self-contained? .....

4. SIGN required: ..... SIGN *not* required: .....

5. Will backwall and dividers be required? (see sketch on reverse side): .....

6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear backwall .....

7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. ....

8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: .....

Return application to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey,  
P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

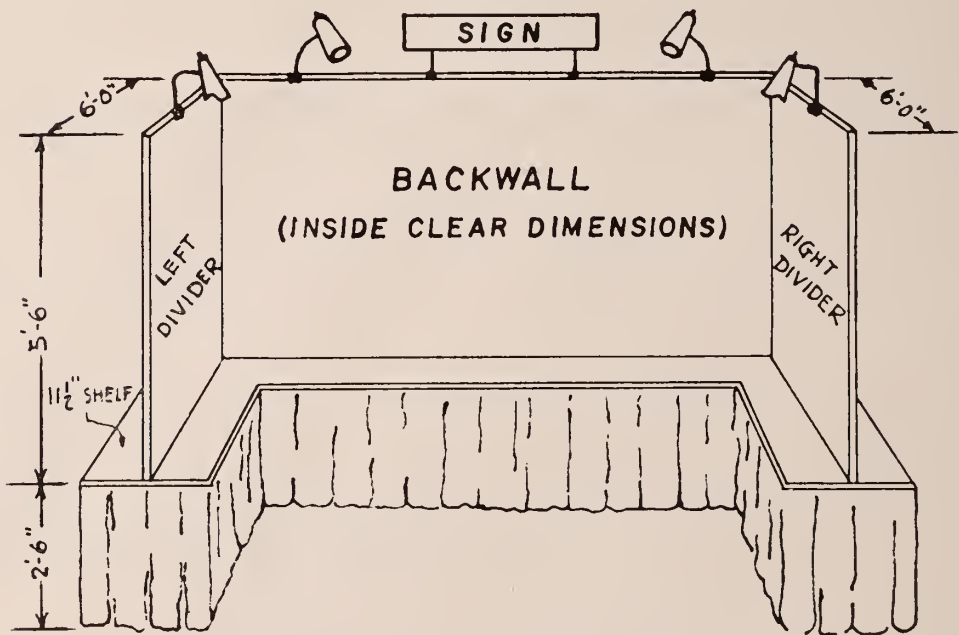
# STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

## ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Overhead lights	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

If your exhibit will not require backwall, or left or right dividers, please advise.  
If a sign is incorporated with your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM



# Upjohn's low-priced erythromycin



**E-Mycin<sup>®</sup>**  
(erythromycin, Upjohn)  
Available in 250 mg tablets

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JAT2-2141-6



## Are they too old to swing?

### EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol .....	0.005 mg.
Methyltestosterone .....	1.25 mg.
L-lysine .....	100 mg.
Ferrous Nicotinate .....	17.85 mg.
Equivalent to Nicotinic Acid .....	12.5 mg.
Ferrous Iron .....	2.82 mg.
Vitamin A .....	2,500 U. S. P. Units
Vitamin D .....	250 U. S. P. Units
Thiamine Mononitrate .....	2.5 mg.
Riboflavin .....	2.5 mg.
Ascorbic Acid .....	25.0 mg.
Folic Acid .....	0.125 mg.
Vitamin B-12 .....	1.5 mcg.
Methionine .....	12 mg.
Choline Bitartrate .....	15 mg.
Inositol .....	10 mg.
Calcium Pantothenate .....	2.5 mg.
Pyridoxine .....	0.25 mg.
Copper (from Copper Sulfate) .....	0.25 mg.
Zinc (from Zinc Oxide) .....	0.25 mg.
Iodine (from Potassium Iodide) .....	0.075 mg.
Calcium (from Dicalcium Phosphate) ..	72.5 mg.
Phosphorus (from Dicalcium Phosphate) .....	55 mg.
Potassium (from Potassium Sulfate) ..	2.5 mg.
Manganese (from Manganese Sulfate) ..	0.5 mg.
Magnesium (from Magnesium Sulfate) ..	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

**ACTION AND USES—DOSAGE:** 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 30, 100, and 500 tablets. Rx only.

## Testand-B tablets

*A hormonal, nutritional supplement*

**Geriatric Pharmaceutical Corp.**

Floral Park, New York 11001

*Pioneers in Geriatric Research*



# ANNOUNCEMENTS

## Clinical Application of Basic Sciences

The Burlington County Memorial Hospital announces the following programs for November and December in its series on clinical application of the basic sciences.

November 2	Community Mental Health Problems
November 9	New FDA Regulations
November 16	Diet Therapy—Fact or Fallacy
November 30	Iatrogenic Neurological Disorders
December 7	Thrombophlebitis and Thromboembolic Diseases
December 14	Anticoagulant Therapy

These lectures, which are supported by education grants from Merck, Sharp, and Dohme, are held at the T. J. Summey Building of the hospital and convene promptly at 3:30 p.m. The American Academy of Family Practice gives one and a half credits per session. Further information may be obtained from the Department of Medical Education of the hospital (175 Madison Avenue, Mount Holly.)

## Loeser Memorial Lecture

The Lewis S. Loeser Memorial Lecture for 1972 will be given on Wednesday evening, November 8, at the VA Hospital on Tremont Avenue in East Orange. Essayist is L. S. Kubie, M.D., Clinical Professor of Psychiatry at the University of Maryland. Dr. Kubie's topic is "Unsolved Problems in the Achievement of Therapeutic Results in the Outpatient Setting." This lectureship is sponsored by the Mental Health Association of Essex County as a memorial to Lewis H. Loeser, M.D., whose contributions to psychiatry and neurology in this state are so well known.

## Psychiatric Graduate Programs

Under the cosponsorship of the Academy of Medicine of New Jersey, Fair Oaks Hospital in Summit announces the following schedule of continuing education programs on the days indicated. All sessions convene at 3 p.m.

November 15	Technics of Hypnosis in Psychiatry Habiba A. Koblenzer, M.D.
November 30	Hypnosis in Psychiatry—Case Selection Habiba A. Koblenzer, M.D.

December 13	Hypnosis in Psychiatry—Clinical Cases Habiba A. Koblenzer, M.D.
January 4	Drug Addiction Edward Wolfson, M.D.
January 17	Proper Use of Antibiotics Dominic A. Mauriello, M.D.

The hospital is located at 19 Prospect Street. For further information please write to Granville L. Jones, M.D., Director of Research and Education, Fair Oaks Hospital, Summit, New Jersey 07901. Additional programs will appear in future issues.

## Radiologic Seminars

Additional programs in the Rutgers Medical School (CMDNJ) series of seminars in radiology are as follows:

December 13	Benign Bone Tumors Meyer Alpert, M.D. Franklin General Hospital
January 17	Vascular Aspects of Scleroderma William J. Casarella, M.D. Columbia-Presbyterian Medical Center
February 14	Radiology Data Acquisition Systems Mrs. Dorothea Aronson Milton S. Hersey Medical Center

Meetings are held the third Wednesday of each month and convene at 5 p.m. in Link Room 203 at the Basic Science Building, Rutgers Medical School, New Brunswick. There is no fee. Additional information is available from Charles P. diLiberti, M.D., Raritan Valley Hospital, 257 Greenbrook Road, Green Brook, New Jersey 08812.

## Graduate Program—Caribbean Cruise

Reservations are now being accepted for the Fourteenth Graduate Medical Seminar Cruise (January 5 to 22, 1973) of Albany Medical College. This is an 11-day trip from New York aboard the Gripsholm of the Swedish-American Line. Ports of call include St. Maarten, Martinique, Barbados, St. Vincent, Grenada, Curacao, Antigua, and St. Croix. The faculty of the Albany Medical College will present a shipboard graduate program covering subjects in pediatrics, psychiatry, surgery, hematology, and physiology. Request has been made for



credit by the American Academy of Family Practice. For further information please write Frank M. Woolsey, Jr., M.D., Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

### **Eye Conference in Philadelphia**

The Wills Eye Hospital announces that February 1, 2, and 3 (1973) will be the dates and Philadelphia's Bellevue-Stratford the place for their 24th Annual Conference. This year's agenda includes material on cataract surgery, keratoplasty, and ophthalmic anesthesia. Workshops will be offered on plastic surgery, eye infections, retinal disease, low vision, and ocular motility. For more details, write to Dr. Robert Mulberger, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia 19130.

### **Otology—Laryngology Courses**

The University of Illinois announces a graduate course in laryngology and bronchoesophagology from March 5 to 10, 1973. The program is limited to 15 physicians on a first-registered, first-accepted basis. It includes practice in the University clinic, animal demonstrations, and lectures. If interested, write for details to the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612.

Also at the Infirmary on West Taylor Street, Chicago, a course in neuro-otology will be conducted from March 26 through 29, 1973. This covers basic test procedures, nystagmography, management of patients with neuro-otologic problems, and correlations with audiometry. For more details, write to the Department of Otolaryngology of the Infirmary at the above address.

### **Continued Education Seminar**

February 25, 1973 through March 3 are dates for the session of the American Society of Contemporary Medicine and Surgery. This meeting will be held at the Fontainebleau in Miami Beach. These courses are approved for continuing education credit by the AMA. Michael DeBakey, M.D., President of the Society will give the keynote address. The Bobst lecture on cancer will be included in this

program. For more details, write to Miss Virginia Kendall, Room 1629, 30 North Michigan Avenue, Chicago 60602.

### **Provocative Allergy Course**

On March 10 and 11, 1973, a course will be offered in Mobile, Alabama, on intradermal food testing and food injection therapy. The program will be held at the Admiral Seemes Hotel in Mobile. Other topics to be covered include inhalants, chemicals, fungi, yeasts, terpenes, air-pollutants, insects, and contact dermatitis. Registration fee of \$125 includes one dinner, two luncheons, and tuition. For more details, write to Joseph B. Miller, M.D., 273 Azalea Road, Mobile, Alabama 36609.

### **Proctology Conference in Far East**

The International Academy of Proctology, which has its offices in Flushing, New York, announces a teaching seminar in the Far East, April 29 to May 14, 1973. Meetings will be held in Tokyo, Hong Kong, Thailand, and Bangkok. You may get details from the Executive Offices of the Academy at 147-41 Sanford Avenue, Flushing, New York 11355, attention Alfred J. Cantor, M.D., Executive Officer.

### **Multiple Sclerosis Association of New Jersey**

Patients with multiple sclerosis, and their families, should be told of the Multiple Sclerosis Association of South Jersey. The address is P.O. Box 187, Oaklyn, New Jersey 08107—telephone (609) 858-3211. At no expense to the patients, this organization helps multiple sclerosis victims in a variety of supportive and educational ways. For more details, write to the Association.

### **Widows and Orphans Society**

Support the Society for Relief of Widows and Orphans of Medical Men of New Jersey. Write to P.O. Box 95, Belleville, New Jersey, for information.

---

# LETTER TO THE JOURNAL

---

## Viral Cultures Available in New Jersey

September 5, 1972

Dear Sir:

In the August 1972 issue of *The Journal* of The Medical Society of New Jersey an article appears by Dr. Richard R. Gove describing an outbreak of hand, foot, and mouth disease. In this article Dr. Gove stated that viral cultures were not done because of the lack of suitable laboratory facilities. Actually, laboratory facilities to establish the etiology of out-

breaks of viral diseases are available to all physicians in New Jersey. For years, the State Health Department has maintained a virus diagnostic laboratory. It has had a special interest in working up outbreaks of suspected viral disease. Indeed there have been several instances where outbreaks of hand, foot, and mouth disease have had a viral etiology established through the use of the virology laboratory of the State Department of Health. We would suggest that when physicians suspect an outbreak of viral disease, they contact the State Department of Health to arrange for proper laboratory services in an attempt to find the exact viral etiology.

(signed) Ronald Altman, M.D.

Director, Epidemiologic Services  
New Jersey Department of Health

---

## MEETINGS OF MEDICAL INTEREST

---

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

### November

8 Academy of Medicine of New Jersey  
Princeton Medical Center  
Princeton  
Venereal Disease

8 Academy of Medicine of New Jersey  
Holy Name Hospital, Teaneck  
Marantology

8 Academy of Medicine of New Jersey,  
Academy of Family Practice, and  
Newark Beth Israel Medical Center  
St. Michael's Medical Center  
Newark  
Thyroid Physiology and Abnormalities

8 Academy of Medicine of New Jersey,  
Academy of Family Practice, and  
Clara Maass Memorial Hospital

Clara Maass Memorial Hospital  
Belleville  
Neurophysiology and Behavior

8 Academy of Medicine of New Jersey  
and Bergen Pines County Hospital  
Bergen Pines County Hospital  
Paramus  
Nephrotic Syndrome

8 New Jersey Academy of Ophthalmology  
and Otolaryngology  
Robert Treat Hotel, Newark  
Annual Fall Meeting

8 Dover General Hospital, St. Clare's  
Hospital and Riverside Hospital  
Dover General Hospital  
Dover  
Anticoagulants and Thrombolytic Agents

9	Burlington County Memorial Hospital Mount Holly FDA Regulations and Medical Practice	21	Academy of Medicine of New Jersey Overlook Hospital, Summit Proper Use of Antibiotics
14	Academy of Medicine of New Jersey Paul Kimball Hospital, Lakewood Hypertension	22	Academy of Medicine of New Jersey, Academy of Family Practice, and Newark Beth Israel Medical Center St. Michael's Medical Center Newark Disorders of the Pituitary and Hypothalamus
14	Academy of Medicine of New Jersey Bloomfield Palmar and Plantar Dermatitis	22	Academy of Medicine of New Jersey, Academy of Family Practice, and Clara Maass Memorial Hospital Clara Maass Memorial Hospital Belleville New Concepts in Antibiotics
14	Academy of Medicine of New Jersey Morristown Memorial Hospital Morristown Treatment of Prostatic Cancer	22	Academy of Medicine of New Jersey and Bergen Pines County Hospital Bergen Pines County Hospital Paramus Management of Tuberculosis
15	Academy of Medicine of New Jersey, Academy of Family Practice, and Newark Beth Israel Medical Center St. Michael's Medical Center Newark Parathyroids and Calcium Metabolism	22	Academy of Medicine of New Jersey John E. Runnells Hospital Berkeley Heights Chemotherapy in Malignant Diseases
15	Academy of Medicine of New Jersey, Academy of Family Practice, and Clara Maass Memorial Hospital Clara Maass Memorial Hospital Belleville Genetic Disease	28	Academy of Medicine of New Jersey Hoffmann-LaRoche Auditorium Nutley The Weed System
15	Academy of Medicine of New Jersey and Bergen Pines County Hospital Bergen Pines County Hospital Paramus Anginal Pain	29	Academy of Medicine of New Jersey, Academy of Family Practice, and Newark Beth Israel Medical Center St. Michael's Medical Center Newark Normal and Abnormal Gonadal Function
15	Pennsylvania Hospital and New Jersey Academy of Family Physicians John F. Kennedy Hospital Edison The Geriatric Patient	29	Academy of Medicine of New Jersey, Academy of Family Practice, and Clara Maass Memorial Hospital Clara Maass Memorial Hospital Belleville Problems with Commonly-Used Hospital Drugs
16	Burlington County Memorial Hospital Mount Holly Diet Therapy—Fact or Fallacy	29	Academy of Medicine of New Jersey and Bergen Pines County Hospital Bergen Pines County Hospital
17 and 18	Academy of Medicine of New Jersey and New Jersey Medical School (CMDNJ) 100 Bergen Street, Newark Symposium on the Knee		



- Paramus  
Diseases of the Parathyroid
- 29 **Dover General Hospital, St. Clare's Hospital and Riverside Hospital**  
Dover General Hospital  
Dover  
Newer Antibiotics and Problem Infections
- 30 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**  
Hospital Center at Orange  
Interesting x-rays of the Month
- 30 **Burlington County Memorial Hospital**  
Mount Holly  
Iatrogenic Neurological Disorders
- December**
- 5 **Academy of Medicine of New Jersey**  
West Jersey Hospital  
Camden  
Renal Failure
- 6 **Academy of Medicine of New Jersey**  
Hoffmann-LaRoche Auditorium  
Nutley  
Application of Laboratory Tests
- 6 **Academy of Medicine of New Jersey and Bergen Pines County Hospital**  
Bergen Pines County Hospital  
Paramus  
Gallbladder Disease
- 6 **Academy of Medicine of New Jersey**  
Princeton Medical Center  
Princeton  
Treatment of Shock
- 6 **Academy of Medicine of New Jersey**  
New Jersey State Hospital, Ancora  
Hammonton  
Alcoholism
- 6 **Academy of Medicine of New Jersey, Academy of Family Practice, and Clara Maas Memorial Hospital**  
Clara Maas Memorial Hospital  
Belleville  
Renal Disease
- 6 **Pennsylvania Hospital and New Jersey Academy of Family Physicians**
- John F. Kennedy Hospital  
Edison  
Drug Therapy in Family Practice
- 7 **Academy of Medicine of New Jersey**  
Martland Hospital, Newark  
Non-Medical Use of Drugs
- 7 **Burlington County Memorial Hospital**  
Mount Holly  
Thrombophlebitis and Thromboembolic Diseases
- 13 **Academy of Medicine of New Jersey and Bergen Pines County Hospital**  
Bergen Pines County Hospital  
Paramus  
Cardiomyopathies
- 13 **Academy of Medicine of New Jersey**  
Helene Fuld Hospital  
Trenton  
Newer Concepts of Hepatitis
- 13 **Dover General Hospital, St. Clare's Hospital and Riverside Hospital**  
Dover General Hospital  
Dover  
Hyperlipoproteinemia
- 13 **Pennsylvania Hospital and New Jersey Academy of Family Physicians**  
John F. Kennedy Hospital  
Edison  
Psychiatric Emergencies
- 14 **Burlington County Memorial Hospital**  
Mount Holly  
Anticoagulant Therapy
- 20 **Bergen Pines County Hospital**  
Paramus  
CPC Meeting
- 20 **Academy of Medicine of New Jersey**  
John E. Runnells Hospital  
Berkeley Heights  
Critically Ill Patient
- 1973  
January
- 3 **Academy of Medicine of New Jersey and Bergen Pines County Hospital**

- |    |  |    |   |
|----|--|----|---|
|    | Bergen Pines County Hospital<br>Paramus<br>Advances in Viral Hepatitis   |    | Paramus<br>Variants of Rheumatoid Arthritis   |
| 4  | Academy of Medicine of New Jersey<br>Fair Oaks Hospital<br>Summit<br>Drug Addiction  | 24 | Academy of Medicine of New Jersey<br>and Bergen Pines County Hospital<br>Bergen Pines County Hospital<br>Paramus<br>Acupuncture                         |
| 10 | Academy of Medicine of New Jersey<br>Princeton Medical Center<br>Princeton<br>Renal Failure  | 25 | Academy of Medicine of New Jersey<br>and Radiological Society of New Jersey<br>Hospital Center at Orange<br>Interesting X-rays of the Month             |
| 10 | Academy of Medicine of New Jersey<br>and Bergen Pines County Hospital<br>Bergen Pines County Hospital<br>Paramus<br>Medical-Surgical Cardiology Conference | 29 | Academy of Medicine of New Jersey<br>New Jersey State Hospital, Ancora<br>Hammononton<br>Congestive Heart Failure                                       |
| 14 | Academy of Medicine of New Jersey<br>Radiology Section<br>St. Barnabas Medical Center<br>Livingston<br>Carcinoma of the Ovary                              | 31 | Academy of Medicine of New Jersey<br>Morristown Memorial Hospital<br>Morristown<br>Proper Use of Antibiotics  |
| 17 | Academy of Medicine of New Jersey<br>and Bergen Pines County Hospital<br>Bergen Pines County Hospital  | 31 | Academy of Medicine of New Jersey<br>and Bergen Pines County Hospital<br>Bergen Pines County Hospital<br>Paramus<br>Idiopathic Thrombocytopenic Purpura |

---

## OBITUARIES

---

### Dr. Raul Z. Bazan

Born in Cuba in 1927, Raul Z. Bazan, M.D., was graduated in 1960 from the medical school at the University of Havana. He did general practice there until he emigrated to the United States in 1967. He worked at the St. Barnabas Hospital in Livingston, New Jersey until March 1970 when he started his too-brief career in private practice. He served the people of Rahway and was a member of our Union County component society. He was affiliated with the Rahway Hospital. Dr. Bazan died on September 20, 1972 at the age of 45.

### Dr. Nicholas Chylak

Nicholas Chylak, M.D., was born in Austria in 1908. He was graduated in 1934 from the medical school at Lvov in Poland and came to New Jersey in 1955. Dr. Chylak was a family practitioner who had served at the St. Francis, Margaret Hague, and Fairmount Hospitals in Jersey City and was a member of our Hudson County component society. He died on August 14, 1972 at the age of 64.

### Dr. David T. DuBow

At one time president of the New Jersey Industrial Medical Association, David T. DuBow, M.D., died on the last day of August 1972 at the age of 72. He was a 1929 graduate of Columbia University's College of Physi-

cians and Surgeons and was an internist with a special competence in industrial medicine. He was a member of our Somerset County Medical Society, a Fellow of the College of Chest Physicians, and served on the staffs of the Muhlenberg Hospital in Plainfield, the Somerset Hospital in Somerville, and the Roosevelt Hospital in Metuchen.

#### **Dr. Raymond J. Gadek**

A tragic automobile accident took the life of Raymond J. Gadek, M.D., on August 28, 1972. Dr. Gadek, a 1954 graduate of Georgetown Medical School, was attending cardiologist at the Perth Amboy General Hospital. Born in 1920, he was 52 at the time of his death.

#### **Dr. Edward R. Gorman**

At the untimely age of 37, Edward R. Gorman, M.D., of Cinnaminson, died on September 16, 1972. His field was child psychiatry and he was Assistant Clinical Professor in his specialty at the Hahnemann Medical School. He was also on the staff of the Rancocas Valley Hospital in Willingboro. Dr. Gorman was a member of the Burlington County Medical Society.

#### **Dr. Parker A. Groff**

Born in 1890, Parker A. Groff, M.D., practiced in Bergen County for many years. In 1959, at the age of 69 he retired to Florida, and died there on September 7, 1972. During his years in New Jersey he was physician to the board of health, and was the school, police, and fire physician in his home community of Little Ferry. Dr. Groff was a general practitioner and considered one of the leading family doctors in that part of Bergen County.

#### **Dr. Henry Haywood**

In 1906, Henry Haywood, then a youth of 22, was rated as "an outstanding track star, one of the best runners in the East." In 1913 he entered the medical school of Cornell University, receiving his M.D., in 1917. He subsequently became a general surgeon with a special interest in traumatic surgery. He was a member of the Middlesex County Medical Society and was affiliated with both hospitals in

New Brunswick, as well as the Rehabilitation Hospital in North Brunswick and the Roosevelt Hospital in Edison. Dr. Haywood retired in 1966 and died on September 17, 1972 at the age of 88.

#### **Dr. Marshall D. Hogan**

Morristown lost one of its best-known urologic and proctologic surgeons on September 12, 1972, with the death that day of Marshall D. Hogan, M.D. Dr. Hogan was born in 1895 and was graduated in 1927 from the Rush Medical College of Chicago. He served the people of Morris County from 1928, when he completed his internship, to 1960, when he retired. He had been on the staffs of Morristown Memorial Hospital and was a consultant to Greystone Park Psychiatric Hospital.

#### **Dr. Elwood Macpherson**

One of our state's best-known internists and one of the founders of the New Jersey Diabetes Association, Elwood H. Macpherson, M.D., died on September 24, 1972. He was a graduate of the Long Island College of Medicine, class of 1924. He was born in Morristown in 1897 and served the people of West Essex for 43 years. He had several years as chief of staff at the Overlook Hospital and had organized the cardiology service there. Dr. Macpherson was responsible for Overlook's first electrocardiogram. He was, for a while, secretary of the State Medical Milk Commission and was a Fellow of the Academy of Medicine of New Jersey and a member of the Essex County Medical Society.

#### **Dr. Edward R. Marshall**

A former Lieutenant Colonel in the U.S. Army Medical Corps, Edward R. Marshall, M.D., died on August 19, 1972, at the age of 61. He had been graduated from the medical school of the University of Michigan in 1938 and became a pioneer in radiology. He was in the military service from 1949 until 1964, and then came to practice in Margate. Dr. Marshall was a member of the Atlantic County Medical Society and on the radiologic staff of the Bridgeton Hospital in Bridgeton.



---

# BOOK REVIEWS

---

**Questions Parents Ask About Their Children.** Robert F. L. Polley, M.D. Bellevue, Washington, Parents Handbooks, 1972. Pp. 164. Illustrated. (Paperback—\$3)

Considering the tendency of physicians to be individualists, it is not likely that any book for the general public will meet with general acceptance by our profession. This book is no exception.

It is my understanding that courtesy copies of this small book are available to physicians. Write to the publisher, Parents Handbooks, 1197-112th, N.E., Bellevue, Washington 98004. Read the book and decide if you would like to encourage parents of your pediatric patients to become familiar with Dr. Polley's approach. I encourage parents to read widely, having warned them before that this will expose them to some confusion and to many honest differences of opinion. Teaching parents to cope with confusion and with differences of opinion is part of good parent education.

The section on the sudden infant death syndrome is excellent. The comments on minimal brain dysfunction are not. This latter is more common than Dr. Polley implies. The sample letters Dr. Polley has written to schools about children with learning problems are well worth reading and emulating. The section on recurrent otitis media is good, except that I feel that tonsillectomy is not of any value for these children. I do not agree with Dr. Polley's comments about the desirability of propping bottles for infant feedings, nor do I agree about the advisability of clipping tongue ties.

Though I mostly agree, the section on drug abuse is too rigid and authoritarian. The definition of professional services on page 156 is superb. The suggestion that low-fat milk is better milk generally than whole milk after age three months is a good one. I am not sure that "alcohol is too irritating" for the neonatal navel. I am not sure that hemangiomas of the eyelid and the genital area necessarily need treatment.

The ideal solution to the problem of parent education is for each physician to write his own book. In the meantime it would seem reasonable to encourage parents to read everything. Dr. Polley's book with its question and answer format is definitely readable.

Solomon J. Cohen, M.D.

**Review of Medical Microbiology,** 10th Edition. Ernest Jawetz, M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. Los Altos, California, Lange, 1972. Pp. 518. Illustrated (\$8)

This firmly-bound, attractive paperback weighs about 1½ pounds. This book, however, should not be judged by its relatively small size or light weight, as it is indeed a comprehensive and current review of medical microbiology and the basic sciences as they apply to infectious diseases. The table of contents lists 40 chapters beginning with the microbial world and continuing with classification, genetics, metabolism, and so on for nine chapters in the basics of modern microbiology. Chapters 10, 11, 12, and 13 deal with anti-

microbial chemotherapy, host-parasite relationships, antigens and antibodies, and allergy and hypersensitivity. These four chapters are a treasure-house of information in these fields which are advancing so rapidly. Chapters 14 through 39 discuss the various bacterial groups, rickettsial disease, and on through the various viruses important in human medicine. Chapter 40 is an excellent review of the oncogenic viruses by Doctor Matilda Benyesh-Melnick. There is an "appendix" of 30 pages on medical parasitology; here also is a wealth of information authored by Doctor J. Ralph Audy and Doctor Fred L. Dunn.

According to the preface, this book is directed to medical students, house officers, and practicing physicians. I agree with enthusiasm and would add to the list clinical microbiologists and medical technology students. Also, for physicians, this book is excellent for just general browsing and as a reference. For the latter purpose the index is complete and well organized. As each bacterium is discussed, there are included some concise and precise comments on the pathology and treatment of disease caused by this organism.

It is a good book and I have gained both knowledge and enjoyment from this review.

Hugh F. Luddecke, M.D.

**Dealing With Drug Abuse.** The Ford Foundation, foreword by McGeorge Bundy. New York, Praeger Publishers, 1972. Pp. 396. (\$8.95)

The Ford Foundation sponsored this survey of the drug problem. It includes seven staff papers, only one by a physician—that one dealing with altered states of consciousness. Otherwise, physicians' contributions are conspicuous by their absence. The drug orientation of modern society, as well as modifications in the life style of young people, are here reviewed. It is suggested that if we cut down on the use of and availability of tranquilizers, we might find a rise in violent crimes or child beating. Emphasis on the abuse of drugs like marihuana and heroin is contrasted with the popular lethargy with respect to the abuse of alcohol—a far more widespread danger.

The editors express concern over the trivial results of expanded efforts in drug education and the danger of glamorization produced by the popular idea of using addicts or ex-addicts as teachers of the subject. The feebleness of our therapeutic programs is exemplified by the fact, cited by the authors, that 90 per cent of all heroin addicts are not in any treatment program at all. Methadone, it is felt, is worth trying, though it tends to be used on older addicts who are often at the point, in the natural history of addiction, where they would be phasing out anyway. Individual psychiatric therapy, the contributors feel, has generally turned out to be a broken reed on which to lean. It is suggested that the British system of narcotic maintenance "appears to have succeeded in containing the problem in Britain." The project suggests that when illegal drugs are only for personal use, not resale, the criminal penalties should be abandoned. The authors want to see a non-governmental, nonprofit "Drug Abuse Council" set up under the aegis of various private foundations and organizations. This Council, they feel, should stay away from the law enforcement part of the operation.

All in all, this is a fact-packed book that gives useful information and stimulates thought on the subject.

Henry A. Davidson, M.D.



**GREENBROOK  
MANOR**  
NURSING HOME

**"A NEW CONCEPT  
IN GERIATRIC CARE"**

Greenbrook Manor offers your patients two levels of nursing care—at commensurate rates—in the same building.

Intermediate Care—for the patient who requires minimal care while participating in a well organized and implemented program of social, educational and therapeutic activities.

Skilled Care—for the patient who requires intensive supervision and care.

**OPEN STAFF POLICY**

303 ROCK AVENUE  
GREEN BROOK, NEW JERSEY 08812  
(201) 968-5500

**THE MEDICAL SOCIETY OF NEW JERSEY**

**Professional Liability Insurance Program**

**Society Endorsed Coverages—**

- Professional Liability for  
Individuals  
Partnerships and Professional Corporations  
Employed Nurses, Technicians or Aides
- Professional Premises
- Excess (Umbrella) Liability—Limits up to \$5 Million

**Management of Loss Control Program—**

- Claims Peer Review
- Prompt Advice Regarding Potential or Actual Claims
- Defense by Highly Skilled and Experienced Counsel
- Investigation by Specialists in Malpractice

**JOSEPH A. BRITTON AGENCY**

15 South Munn Ave., East Orange, N.J. 07018  
(201) • 673-3060

## **NEW JERSEY**

**FULL TIME**

**ALL SHIFTS AVAILABLE**

**NEW JERSEY LICENSE REQUIRED**

APPLY: R. J. Matthews, Personnel Director, Point Pleasant Hospital, Osborn Avenue and River Front, Pt. Pleasant, N.J. 08742  
Phone (201) 892-1100

**PHYSICIANS WANTED:** Psychiatrist—Immediate openings to work on Psychiatric Services. Also openings in community mental health clinics in need of expansion. Jersey Shore Area. Excellent personnel programs and benefits. May have part time practice. State License required. Salary to \$29,714.00 depending on qualifications. Send resume in confidence to Michael R. Simon, M.D., Medical Director, Marlboro Psychiatric Hospital, Marlboro, New Jersey. Telephone: 201-946-8100.

## **EMERGENCY ROOM PHYSICIAN**

For 500 bed General Hospital in a pleasant suburban community, 20 miles from N.Y.C. New modern Emergency Room facilities. Excellent salary plus fringe benefits.

**Contact: Personnel Director  
Overlook Hospital  
193 Morris Avenue  
Summit, New Jersey 07901**

## **INDUSTRIAL CLINIC PHYSICIAN**

Wanted for northern N. J. Clinic. Full or part time. Normal work hours—no weekends. Liberal benefits. Submit resume to: Box No. 23, c/o THE JOURNAL.

## **INTERNS NEEDED**

General Practice for 87-bed fully accredited community hospital in Southern New Jersey. E.C.F.M.G. Certificate — \$17,000—Blue Cross/Blue Shield—Midway Philadelphia — Atlantic City 30 minutes away — Opening immediately. Send full particulars to Box No. 21, c/o THE JOURNAL.

## **MORRIS COUNTY**

Excellent opportunity for doctor interested in starting a new practice. Lovely Home and Office Combined, Large Office, 2 Examining Rooms, near a very busy hospital. Formerly operated by a Pediatrician that has retired. Easy terms can be arranged. For more details consult

Kohler & Catlin, Inc., Realtors  
116 E. Blackwell Street  
Dover, N.J. 07801  
(201) 366-6600

## **FOR SALE OR LEASE**

PROFESSIONAL BLDG. COMPLETELY FURNISHED, BRICK BLDG. WITH ALL THE LATEST MEDICAL EQUIPMENT. EXCELLENT LOCATION NEAR IRVINGTON CENTER. 2ND FLOOR OCCUPIED BY OPTOMETRIST WITH EXCELLENT RENTAL. FIRST FLOOR, 9 ROOMS, ALL NEW FURNITURE AND HEATING SYSTEM, COMPLETELY MODERNIZED. A/C PRACTICE MAY ALSO BE BOUGHT.

PRICED FOR QUICK SALE.  
CALL 622-5773 Mon. thru Friday



# CLASSIFIED ADVERTISEMENTS

**AVAILABLE**—Specialty, general surgery. Desires group or partnership. Available October 1972. Write Box No. 31, c/o THE JOURNAL.

**AVAILABLE**—Completing Internal Medicine residency training, IMM. Visa, ECMFG certified. Seeking proper position. Available January 1973. Please contact K. S. Luo, M.D., (201) 753-2000.

**AVAILABLE**—Pediatrician, board eligible, desires to join a group with one or two pediatricians or full time hospital position. Available January 1973. Write Box No. 30, c/o THE JOURNAL.

**AVAILABLE**—Urology, board eligible, military service completed. Available July 1973. Franklin A. Morrow, M.D., 1 Wall Street, Fort Lee, New Jersey 07024. Phone (201) 944-8380.

**CARDIOLOGIST WANTED**—To join three man cardiology group in New Jersey. Broad cardiology practice including pacemakers and cardiac catheterizations. Contact Dr. E. Federici, 520 Westfield Avenue, Elizabeth, New Jersey 07208.

**FOR SALE**—Trenton, home-office, semi-detached brick house near Mercer Hospital in professional area. Lot 50' by 300', ample parking, 3-car block garage. Prominent physician occupies home and office 32 years. Central air-conditioning, oil heat, 4 zones. Office—waiting room, consultation room, 2 examining rooms, 2 tile lavatories, large laboratory, instrument room, large closets. Over office, 5-room modern apartment. Home—8 rooms, 3 baths, ample closets. Home can be easily converted into two units. Will finance. Write Box No. 10, c/o THE JOURNAL.

**INTERNIST WANTED**—To join three man internist corporation in Northwest New Jersey, no investment, all benefits, send biography to Box No. 32, c/o THE JOURNAL.

**GENERAL PRACTITIONER WANTED**—To associate in active practice, Toms River. Excellent opportunity, good hospital affiliation. Reply P.O. Box 4612, Island Heights, New Jersey 08732.

**FOR SALE**—Examining room furniture, steel, color green; examining table, detecto stool, scale, lamp, instrument table, waste receptacle, \$300.00. Write Box No. 33, c/o THE JOURNAL.

**OFFICE SUITE**—Lease, rental, sale; Vineland. Fully equipped by Internist in 1967. X-ray room, 2 examining rooms, consultation room, secretarial pool, waiting room and huge basement for additional dry storage. Phone (201) 692-8051.

**OFFICE SPACE**—Cranford, 1000 square feet suites available to lease or purchase in new professional building under construction. Designed to your needs. Write Box No. 34, c/o THE JOURNAL.

**FOR RENT**—Physician's suite, custom built in modern professional building, 1100 to 1700 square feet. Convenient to two hospitals. Call (201) 239-0022.

**FOR SALE**—Middletown, beautiful office and residence, one hour from New York City and 20 minutes to seashore. Rare opportunity for diverse specialties—open staff at two hospitals, one recently opened. Office approximately 1,000 square feet, costly extras. Must see to fully appreciate. Call collect (201) 671-4616.

**Information for Advertisers—RATES:**—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifth of preceding month.

## M. D.—RESEARCH— PHARMACEUTICALS

Several interesting positions with excellent opportunity for advancement on medical research staff of leading pharmaceutical company for M.D.'s interested in long term career dealing with leaders of medical profession. Prior research experience in industry or academia helpful but not essential. Particularly interested in individual with post graduate training in fields of internal medicine, pediatrics, anesthesiology, clinical pharmacology or public health from first line medical institutions in U.S., Great Britain or Canada. Licensure or capability of licensure in New York or New Jersey desirable. Base low to middle 30's plus approximate 40% fringe. Location suburban Middle Atlantic. For details write or call collect:

### PACKARD ASSOCIATES

3 Water Lane, Manhasset, N.Y. 11030  
516 MA 7-0656

## STATE OF NEW JERSEY

### Residency in Public Health

Three years (second year is to obtain a Master's Degree in Public Health on salary). Applications being accepted now. One year internship and U.S. citizenship required. Salary \$17,909 to start. Program consists of various activities of the New Jersey State Department of Health. Send resume to:

Marise S. Gottlieb, M.D.

N.J. State Department of Health

P.O. Box 1540, Trenton, N.J. 08625

SOUTHERN, N.J.

## Over 14% NET YIELD

### TAX SHELTER OPPORTUNITY

Well maintained Nursing Home—208 Beds  
—95% Average occupancy—Approved by  
Medicare, VA, Medicaid, N.J. State Welfare.  
Invest \$450,000. over mortgages for better  
than 14% yield after interest, amortization,  
taxes & expenses. Exceptional depreciation  
provides excellent tax shelter. Professional  
management available.



REALTORS SINCE 1890

1373 Broad St., Clifton, N. J. 07013

(201) 473-3400



Let your money grow  
on an Orange Tree

## If you are Self-Employed

Once again, Orange Savings Bank  
is first in the state with this  
unique and distinctive program  
offering outstanding benefits for  
the self-employed.

Doctors, Dentists, Lawyers, Accountants . . .

If you qualify, you can create a substantial  
nest egg for future retirement needs.

Set aside as much as \$2,500 a year, de-  
ducting it from your present taxable income,  
and pay no taxes on the earned high interest  
until you are ready to retire on your funds!

Get complete details today! Mail the coupon  
below for illustrated booklet.

## ORANGE SAVINGS BANK

Offices in Orange • Pequannock  
Hackettstown • Wyckoff • 201-676-5700

Orange Savings  
Bank's RAINBOW  
RETIREMENT PLAN  
can be the tax-saving  
POT of GOLD in  
your future!



Gentlemen: I am  
self-employed and  
want to know  
more about your  
tax-saving  
retirement plan.  
Please send me  
your free booklet.

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Main Office: Orange Savings Bank  
Main Street at Day  
Orange, New Jersey 07050

Member Federal Deposit Insurance Corporation • All deposits insured to \$20,000.



# Look what comes with your Rossmoor home.



## Your own 18-hole par-71 course!

Imagine having an 18-hole, par-71 course with PGA pro right in the community where you live. Within walking distance of your home. Where you can play as frequently as you wish without fighting your way through miserable traffic; without interminable delays waiting to tee off. At a nominal early fee that's only a tiny fraction of the cost of joining a golf or country club.

That's the wonderful world of Rossmoor. Designed for active adults 18 years and over, retired or not.

But golf isn't the only attraction in this unique community. There's

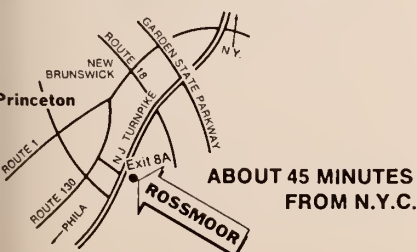
tennis. And swimming in an olympic-size pool. And so many other recreation activities, you'd need a 10-day week to fit them all in.

The real beauty of living at Rossmoor is that you have more time to enjoy all these pleasures. Though you have all the tax advantages and equity build-up that comes with home ownership, you have none of the chores. All the exterior work is done for you here. A trained staff fertilizes, limes and mows your lawn, rakes the leaves, shovels the snow and maintains the exterior of your home.

You also have perfect peace of mind here because Rossmoor is a protected community. With a gateman and a roving security force that protects you 24 hours a day.

If you think it costs a fortune to live here, we have great news for you. The condominium manor homes with 2 bedrooms and 2 baths, G. E. appliances and central air conditioning are priced from \$27,650.

Come live where all the active adults live. At Rossmoor. Where the 19th hole more than likely will be located on your own patio.



*The adult community for active people.*  
**Rossmoor**  
 Monroe Township, N.J. / (609) 655-2270  
 AT EXIT 8A OF THE NEW JERSEY TURNPIKE



Sponsored and developed by  
 GUARDIAN DEVELOPMENT CORP., a publicly-owned company.



# Will his return to work mean the return of undue psychic tension?



states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

## Valium® (diazepam)

For the tense cardiac patient who must be kept calm

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures.

Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision.

Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

ROCHE

Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

2 East 103rd Street  
New York, New York 10029 C

LIBRARY  
NOV 13 1972  
NEW YORK ACADEMY  
OF MEDICINE

the

## JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

## contents

Pages 989 to 1076



## EDITORIALS

Fragmentosis or Unitasis in Medicine? .....	999
Icarus and the Physician-Pilot .....	999
Research: Pure and Applied .....	1000
Health as a Commodity .....	1000

## ORIGINAL ARTICLES

Psychologic Impact of a Coronary Care Unit .....	1001
William A. Layman, M.D., Hackensack	
Erroneous Diagnoses on Admission of Chest Cases .....	1011
Samuel Cohen, M.D. and Rolando M. Bueno, M.D., Jersey City	
Understanding African Students in the United States .....	1017
Amechi Anumonye, Lagos, Nigeria	
Tonsillectomy-Adenoidectomy and Otitis Media .....	1023
William L. Wood, M.D. and Robert I. Oberhand, M.D., Red Bank	
Acute Gastrointestinal Erosions in Critically Ill Patients .....	1029
Victor W. Groisser, M.D., et al., Montclair	
Thrombocytopenic Purpura Following Nonprescription Medication ..	1035
Norman N. Kohn, M.D., Cinnaminson	
Career Commitments in Medicine .....	1037
Stanley S. Bergen, Jr., M.D., Newark	

## SPECIAL ARTICLE

Countdown on National Health Insurance .....	1041
Russell B. Roth, M.D., Erie, Pennsylvania	

## NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes: October 15, 1972 .....	1047
Communicable Diseases in New Jersey .....	1049
Medical College Notes .....	1051
Long-Term Survival Rates in Cancer .....	1052
Scientific Exhibits .....	1053
Physicians Seeking Location .....	1057

ANNOUNCEMENTS .....	1059
MEETINGS OF MEDICAL INTEREST .....	1061
OBITUARIES .....	1063
INDEX .....	1065
BOOK REVIEWS .....	1073

DECEMBER, 1972  
Vol. 69, No. 12

INDEX ISSUE



# THE MEDICAL SOCIETY OF NEW JERSEY

## Endorsed Insurance Plans

### ACCIDENT AND HEALTH INSURANCE

**\$1,200** a month maximum BASIC total disability benefit.  
Accident: from 1st day, up to 5 years (Partial Accident  
Disability, half benefit up to six months)  
↓  
**PLUS** Sickness: from 8th day, up to 2 years  
Accident: may be EXTENDED to Lifetime  
Sickness: may be EXTENDED to 7 years  
↓  
**\$1,000** a month maximum NEW LONG-TERM PLAN.  
Payable up to Lifetime for accident—Age 65 for sickness  
Choice of waiting periods:  
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

★ ★ ★

### LIFE INSURANCE

**\$10,000 to \$150,000** of Convertible Term Life Insurance  
(Guaranteed exchangeable at any time into Permanent Cash  
Value life insurance without medical examination)

**\$10,000 to \$50,000** of Convertible Term Life Insurance  
available for spouse, dependent children  
and employees.

★ ★ ★

### MAJOR EXPENSE INSURANCE

**\$25,000** maximum for Covered Expenses as stated in the policy for each  
accident or sickness, covering member, spouse, and eligible  
children. \$750 deductible, 20% co-insurance. (Physicians' and  
surgeons' fees are not a Covered Expense.)

★ ★ ★

### HOSPITAL-MONEY PLAN

**\$20-\$30-\$40** per day paid for each day that you or your dependents  
are hospitalized, from the first day for as long as 365  
days for any one accident or sickness. Benefits are tax-free.

★ ★ ★

### SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

**\$200,000** maximum for member, covering accidental death, dismember-  
ment, loss of sight, total and permanent disability, exposure  
and disappearance. \$100,000 maximum for spouse (without  
disability benefit).

★ ★ ★

H.R. 10 (KEOGH) RETIREMENT PLAN ★ ★ CORPORATE MASTER PLAN

#### APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations  
for acceptance of risks. New members have special privileges during the first  
few months of membership; ask for specific details if you were recently elected  
or have applied for membership.

*Information and claim service are as close as your telephone.*

**E. & W. BLANKSTEEN AGENCY, INC.**

75 MONTGOMERY STREET, JERSEY CITY, NEW JERSEY 07302

(201) DElaware 3-4340



---

# PUT YOUR TRUST IN NJB

---

Available to physicians and their attorneys at NJB is a complete range of estate and personal trust services, including investment guidance and custody of securities. Our highly-trained specialists have the knowledge and know-how required to effect long-range plans, and the experience necessary for the prudent and profitable management of other people's property. ■ Should you be interested in any of our Trust or Investment Department services, we'd be most happy to discuss them with you.

TRUST OFFICES: 129 Market Street, Paterson  
657 Main Avenue, Passaic

**NEW  
JERSEY  
BANK**

"FOUNDING BANK OF GREATER JERSEY BANKCORP"

---

*Serving Industry with Integrity*



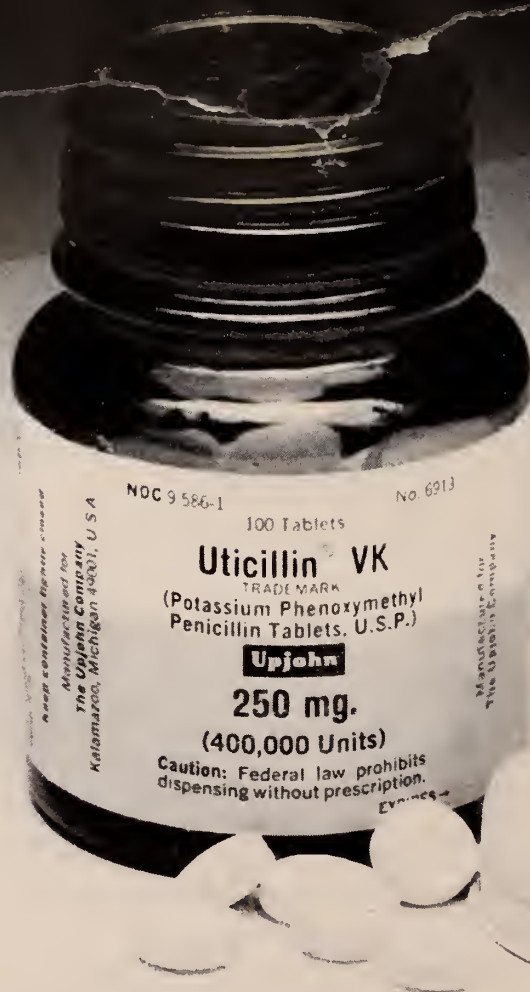
SOUTH MOUNTAIN  
LABORATORIES • INC  
*for CONTROL-RESEARCH*

SERVICES IN

- |                 |                      |
|-----------------|----------------------|
| • PHARMACOLOGY  | • BIO-ASSAY          |
| • ENDOCRINOLOGY | • PLASTIC IMPLANT    |
| • TOXICOLOGY    | • HUMAN SKIN TESTING |
| • COSMETICS     | • BIOAVAILABILITY    |

487 Valley Street, Maplewood, N. J. 07040  
phone (201) 762-0045

# Upjohn's low-priced penicillin VK



## Uticillin<sup>®</sup> VK

(potassium phenoxymethyl penicillin, U.S.P., Upjohn)

Available in 250 and 500 mg tablets;  
250 mg/5 ml and 125 mg/5 ml flavored granules  
for oral suspension

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2144-6



## GREENBROOK MANOR NURSING HOME

### "A NEW CONCEPT IN GERIATRIC CARE"

Greenbrook Manor offers your patients two levels of nursing care—at commensurate rates—in the same building.

Intermediate Care—for the patient who requires minimal care while participating in a well organized and implemented program of social, educational and therapeutic activities.

Skilled Care—for the patient who requires intensive supervision and care.

#### OPEN STAFF POLICY

303 ROCK AVENUE  
GREEN BROOK, NEW JERSEY 08812  
(201) 968-5500

## KESSLER INSTITUTE FOR REHABILITATION

West Orange, New Jersey

- A voluntary, non-profit, non-sectarian specialty hospital and rehabilitation center for physically handicapped children and adults providing intensive and comprehensive medical, social, psychological, and vocational services for patients with any physical impairment due to a congenital condition, accident or disease.
- In-patient and out-patient service facilities include a 48-bed, air-conditioned in-patient wing, swimming pool, and modern treatment facilities.
- Fully accredited by the Joint Commission of Accreditation of Hospitals, and the Commission on Accreditation of Rehabilitation Facilities.
- Provider of Services under Medicare and Medicaid.

ADMISSION BY MEDICAL REFERRAL TO  
DIRECTOR OF ADMISSIONS

RICHARD A. SULLIVAN, M.D.,  
Medical Director

HENRY H. KESSLER, M.D.,  
Director of Professional  
Education and Research

WILLIAM K. PAGE, Executive Director  
Telephone: 731-3600

# MUNICIPAL BONDS IS OUR BUSINESS ...OUR ONLY BUSINESS!

For further information call or write

## Hanauer, Stern & Co.

12 MJ

1180 Raymond Boulevard, Newark, N.J. 07102

(201) 623-3233

NAME.....PHONE.....

ADDRESS.....

CITY.....STATE.....ZIP.....



# THE MEDICAL SOCIETY OF NEW JERSEY

*Founded July 23, 1766*

## Officers and Trustees

### PRESIDENT

William J. D'Elia, M.D. (Monmouth) ..... Neptune City

### PRESIDENT-ELECT

Matthew E. Boylan, M.D. (Hudson) ..... Jersey City

### FIRST VICE-PRESIDENT

James A. Rogers, M.D. (Passaic) ..... Paterson

### SECOND VICE-PRESIDENT

John J. McGuire, M.D. (Essex) ..... Newark

### IMMEDIATE PAST-PRESIDENT

E. Vernon Davis, M.D. (Burlington) ..... Mount Holly

### SECRETARY

Louis F. Albright, M.D. (Monmouth) ..... Spring Lake

### TREASURER

Samuel J. Lloyd, M.D. (Mercer) ..... Trenton

## Trustees

### CHAIRMAN

A. Guy Campo, M.D. (1973) (Gloucester) ..... Westville

### SECRETARY

David Eckstein, M.D. (1975) (Mercer) ..... Trenton

Robert C. Anderson, M.D. (1975) (Essex) ..... Newark

Francis J. Benz, M.D. (1973) (Morris) ..... Chatham

George L. Benz, M.D. (1974) (Essex) ..... Newark

Edward J. Bourns, M.D. (1975) (Union) ..... Westfield

Harold L. Colburn, Jr., M.D. (1973) (Burlington) Mount Holly

Charles L. Cuniff, M.D. (1975) (Hudson) ..... Jersey City

Richard E. Lang, M.D. (1975) (Passaic) ..... Passaic

Nicholas E. Marchione, M.D. (1974) (Cumberland) Vineland

I. Edward Ornaf, M.D. (1975) (Camden) ..... Camden

Howard D. Slobodien, M.D. (1975) (Middlesex) Perth Amboy

James S. Todd, M.D. (1974) (Bergen) ..... Ridgewood

## Councilors

### FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Thomas S. P. Fitch, M.D. .... Plainfield (1975)

### SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

John L. Olpp, M.D. .... Englewood (1974)

### THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. .... Trenton (1973)

### FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. .... Haddonfield (1975)

### FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

John S. Madara, M.D. .... Salem (1974)

## AMA Delegates

Joseph P. Donnelly, M.D. (1973) ..... Jersey City

Frank J. Hughes, M.D. (1974) ..... Gloucester

John E. Kustrup, M.D. (1974) ..... Trenton

Luke A. Mulligan, M.D. (1974) ..... Leonia

Isaac N. Patterson, M.D. (1973) ..... Westville

Emanuel M. Satulsky, M.D. (1974) ..... Elizabeth



December 1972

## Publication Committee

Daniel B. Roth, M.D., *Chairman*

Arthur Krosnick, M.D.

John F. Marshall, M.D.

## Editor

Henry A. Davidson, M.D.

## Assistant Editor

Marjorie D. Treptow

## Advertising Manager

Joseph W. Cookson

## Executive Director

Richard I. Nevin

*The Journal* is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 820.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription (\$3.50) is included in the dues of Society members.

Subscription rates for nonmembers: \$7 per year (including postage), in advance. Outside USA, postage is additional.

Single copies are \$1.00 each.

Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

Second class postage paid at Trenton, New Jersey, and additional entry office.

Copyright 1972 by The Medical Society of New Jersey.

# Should old depressives be forgot?

geriatric depressive.

Unable to concentrate he tends to have little interest in the affairs of the world around him. His reactions are slow and delayed. He speaks very little. When he does, it's mostly to complain of his insomnia, fatigue, or inactivity.

One way of relieving depression in the geriatric patient is with Tofranil.

Please read the prescribing information for details of usage (lower dosages are recommended for elderly patients and adolescents), precautions, warnings, contraindications, adverse experiences, and dosage recommendations. It is summarized below.

## Tofranil® Geigy imipramine hydrochloride USP



### imipramine hydrochloride USP

**Contraindications:** The concomitant use of this agent with monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or convulsive seizures may occur. Potentiation of effects can be serious or even fatal. An interval of at least 14 days after M.A.O.I. therapy has been completed should be allowed before this drug may be initiated. Initial dosage should be low; increases should be gradual, and the patient's progress should be closely observed. The drug is also contraindicated during the acute recovery period after myocardial infarction. (b) in patients with known hypersensitivity to the drug. Cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of this drug during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformations associated with the use of this drug, but a causal relationship has not been confirmed. Extreme caution should be used when this drug is given to:

patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia; patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic effects;

elderly patients or those on thyroid medication because of the possibility of cardiovascular toxicity;

patients with a history of seizure disorder because the drug has been shown to lower the seizure threshold;

patients receiving guanethidine or similar agents as imipramine may block the pharmacologic effects of these drugs.

**Usage in Children:** Pending evaluation of results from clinical trials in children, the drug is not recommended for use in patients under twelve years of age. The drug may impair the mental and/or

physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

**Precautions:** Because of the possibility of suicide in seriously depressed patients, careful supervision during the early phase of treatment is necessary and hospitalization may be required. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, imipramine may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential.

**Adverse Reactions:** *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurologic:* Numbness, tingling, paresthesias

of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue), drug fever, cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling, alopecia.

**Withdrawal Symptoms:** Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**How Supplied:** Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration. (B)98-146-850-11 (7/71)

**For complete details, including dosage, please refer to the full prescribing information.**

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardley, New York 10502

TO 8575





**if skin is infected,  
or open to infection...  
choose the topical  
that gives your patient—**

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

**Special Petrolatum Base**  
**Neosporin<sup>®</sup> Ointment**  
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.  
In tubes of 1 oz. and ½ oz. for topical use only.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical aftercare, and pyogenic dermatoses.

*Precaution:* As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.



*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug  
products useful in treatment  
involving concomitant use  
of two or more drugs?**

**Opinion**

**Results of a questionnaire to  
7,000 physicians:**

**62.9%**

**Believe combination drug  
products are useful.**

**13.8%**

**Do not believe combination drug  
products are useful.**

# Are combination drug products useful in treatment involving concomitant use of two or more drugs

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in for a number of years that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I am thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosing errors. To take such preparation off the market doesn't seem to be good medicine, unless actual age showed a great deal of harm from the injection (rather than the product) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it is avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making the ultimate decision.



# Maker of Medicine

V. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact, it would be pedantic, to insist they always be described separately. To avoid the appearance of pedantry, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he imputes a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the best of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains respond to 500 mg. of aspirin yet that fact does not militate against the use of a dose being 650 mg. The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Fake antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

What is your opinion, doctor?

We would welcome your comments.



The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005





**Not too little, not too much...  
but just right!**

"Just right" amounts of Ilosone Liquid 250  
can be dispensed easily from the pint bottle in any quantity  
you specify to meet your patients' precise needs—  
without regard to package size.

ready-mixed  
**Ilosone® Liquid 250**

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

*Additional information available  
to the profession on request.  
Eli Lilly and Company  
Indianapolis, Indiana 46206*



100204

---

# EDITORIALS

---

## Fragmentosis or Unitasis in Medicine?

The medical profession today is becoming highly fragmented. There have always been divisions of opinion. There were homeopaths and eclectics and allopaths, but these differences have been largely resolved. There have been osteopaths, most of whose departures from the orthodox medical fold have been eliminated at the scientific level and are resolving at the educational and administrative levels. But as old divergencies disappear, new ones develop.

The American Medical Association survives as the organizational base for the preponderance of practicing physicians and their colleagues in teaching, research, administration, and the like. It is slow to change its policy positions. Perhaps there is no single physician who agrees with them all. As a result, there have been, and continue to be, defections on grounds which may be political, denominational, financial, or philosophical. There are those who might otherwise be content, but who object to the AMA position on abortions as being too liberal or too constrictive, so some of each persuasion split off. There are those who object to the concepts of the way in which the medical profession should deal with government, at arm's length or in close collaboration. There are physicians who are persuaded that the entire delivery system of medical care must be constructed along the principles of dialectic materialism. There are conservatives and ultra-conservatives. There are large numbers of medical students, interns, residents, young physicians, and academicians who follow essentially no leadership, but regard themselves simply as anti-establishmentarian. The question arises as to the survival value of a profession so beset. This might be a highly hypothetical question, were it not for the fact

that the critics of medicine are so willing to move in through legislative avenues to convert the entire profession into a public utility, governmentally operated and peopled by highly educated craftsmen.

There will always be an inability in a middle-ground organization to accommodate extremists. There will inevitably be radical rebellion on the left and reactionary isolationists on the right. They may be left to their own devices. But for the overwhelming majority of professional medical people, there should be some broadening of perspective. The greatest threat to American medicine today is not outside our profession, but within it. If there are things which are not clearly right in the policies of our major medical organization, the work of those who disagree can set them right. The need is for cooperative, constructive strengthening of the position of a great profession. With that strength we need not fear external assaults.

---

Excerpt from editorial by R. B. Roth, M.D., Erie County Medical Society Bulletin, December 1971

## Icarus and the Physician-Pilot

In Greek mythology, Icarus was the man who flew on wings stuck to his body with wax. In a moment of self-grandeur, he flew too close to the sun and the wings melted. End of Icarus. This sad observation is stimulated by a report\* of a Federal Aviation Administration official headline, "Physician-Pilots More Prone to Accidents." Physicians, as plane pilots, were found to have suffered fatal crashes "at a rate four times that of general aviation pilots." Nor were these doctors on life-saving missions of mercy. Indeed, 14 of the 15 fatal accidents occurred when the M.D.-pilots were on pleasure trips. Harold Brown, M.D., Safety Director of the Flying Physicians Association, rejected the figures as mere "name-calling." Although many dentists fly their own planes, no dentist was in a fatal crash in

\* *New York Times*, August 6, 1972

1971, compared with 15 physicians. Autopsies showed in the FAA study that "a significant barbiturate level was found in the blood." It is postulated that physicians, perhaps being more casual about medication than laymen, were more ready to take barbiturates when under emotional tension or when simply keyed up. Another probable factor was the average doctor's brutally long working schedule which had the double effect of leading to recreation which would get him as far away from the office as possible plus the factor of fatigue. On the other hand, blood-alcohol was not found to be disproportionately higher for physician-pilots than for other non-commercial aviators.

Finally, one wonders if the sense of personal indestructability might not have played a role. The FAA official said that "in all 15 fatal cases the physician-pilot committed a highly unsafe act that was deliberate and premeditated." In this connection, one cannot help remembering that physicians have a higher than average suicide rate. Perhaps there are times when the wild blue yonder seems too attractive.

## Research: Pure and Applied

The popular acronym R & D—meaning "Research and Development"—reminds us that in research today the focus is on "what good will it do?" To do research on the pain-killing possibilities of a new drug formula is obviously "practical" research—something that could be put into application as soon as the results are confirmed. To study the physiology of the kidney tubule in invertebrate marine animals seems like a long way from useful research. But the development of effective diuretics may be rooted in precisely this kind of remote-sounding research. A case may even be made for the philosophical position that all knowledge is useful, and anything which advances knowledge is valuable in itself. Or, to put it negatively, there is no such thing as useless knowledge. Myriads of "pure research" studies ultimately led to the

technology that landed men on the moon. Too much of the human body is still cloaked in arcane mystery. We don't really "know" what makes the heart keep beating or what really controls the exchange of gases in the lungs. We know less about the physiology of learning than about a data processing machine. With so much still undiscovered, it would seem as if we need never scorn basic research no matter how "pure" and theoretical it sounds.

## Health as a Commodity

Recent legislation establishing a cancer agency has reinforced the idea that a cure for cancer is a "for sale" item that can be picked off the shelf, if only the money were available. This is part of the modern tendency to think of the physician as a "vendor" of medical services and conjures up a picture of a warehouse of neat packages of "medical care" selling at so much a unit, with the M.D. as the salesman or distributor. The courts right now have to decide whether blood transfusion is a service or whether it is a purchase and sale of a commodity labeled "blood," like the purchase of a quart of oil at a gasoline station.

The concept of health as a vendable commodity is a factor in the current concern about national health insurance programs. One reason that more and more non-physicians are being introduced into these operations is that so much of health care is seen as a mechanism of purchase and sale, with the primary concern being to assure that the price is right. Physicians who have experienced working on a salary basis, rather than on a fee-for-service system—experiences common to army or public hospital practice—soon discover that they do not weaken their sense of interest in or dedication to patient welfare by reason of being paid on a salary basis. Though the hour may be late, perhaps we have travelled too far on the road toward the concept that health is for sale, to change the direction at this time.



---

# ORIGINAL ARTICLES

---

*Here is a patient's view of the Coronary Care Unit, stressing some not so obvious factors.*

## Psychologic Impact of a Coronary Care Unit\*

---

**William A. Layman, M.D./Hackensack**

Although there is a considerable body of literature regarding the emotional impact on the patient who has had a coronary and the subsequent effect of treatment in a coronary care unit, most of the papers have addressed themselves to specific aspects of this experience. There have been few attempts to view the emotional experience of having a myocardial infarction in its totality. However, this very meaningful and significant event in the life of a patient is one which has a specific and identifiable beginning with the onset of cardiac symptoms, a definite time progression, and a recognizable end-point marked either by death or the transfer out of the coronary care unit. It is one of the relatively few dramatic emotional events which can be examined as a continuum both in relationship to and separate from the individual's other psychologic problems. I recognize the likelihood that significant emotional factors are involved in the precipitation of a coronary attack. After transfer out of CCU the emotional impact of having had a myocardial infarction continues to play an important part in the life of the patient. I have chosen, for the purposes of this paper, to examine the experience from the onset of the attack itself to the point when the patient is out of the coronary care unit. Data for this paper are derived from direct personal experience and observation, a number of interviews with coronary patients, and a review of the current literature.

### The Attack

A myocardial infarction is typically described

as the abrupt appearance of severe, persistent substernal pain accompanied by a cold sweat, shortness of breath, severe weakness, and a marked feeling of impending doom.<sup>1</sup> This occurs in most instances without relation to effort or other precipitating cause. It has a dramatic psychologic effect on the patient. The severe anxiety which is usually associated with the attack is particularly noteworthy since it is uncommon with other catastrophic illnesses such as stroke or massive internal hemorrhage. The coronary attack begins with the experiencing of massive anxiety: the patient feels he is dying. The extent and significance of this anxiety is often overlooked in terms of the effect it has on the individual's future adjustment. Many of those interviewed stated that they had never experienced a level of anxiety so intense and so totally out of proportion to the amount of physical pain involved. This frequently overwhelming level of apprehension is often ignored by the treating physician since, in many cases, it has lifted by the time the patient is first examined. Because of the relatively transient nature of the initial anxiety, its importance appears to have been ignored in most studies. It is at this time that the first separation into "deniers" and "non-deniers" takes place. As has been observed by others, there is either a tendency for the patient to seek medical attention immediately because of the severe nature of his complaints or conversely to neglect this discomfort for many hours in the face of obviously severe sympto-

---

\*Read before the Section on Psychiatry and Neurology, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 7, 1972. Dr. Layman is Associate Professor of Psychiatry at the College of Medicine and Dentistry at Newark.

matology. Thus, we find that the individual who may later be a "denier" regarding his entire experience, frequently begins this denial by not calling for medical assistance promptly.

### The Emergency Room

Once medical assistance is sought, the patient is usually taken to an emergency room where his initial apprehension regarding his condition is promptly confirmed and intensified by the rather serious and professional manner of the emergency room staff and by the gravity with which his condition is treated. The prompt initiation of emergency measures such as starting an intravenous, the administration of oxygen, doing an electrocardiogram, and so on may serve either to reassure the patient that he is going to be cared for or, conversely, intensify his already severe concern regarding his condition. And it is here in the emergency room that many tactical errors may be made. For example: In my case the intern's first question to me was, "Is this the first *serious* heart attack you've had?"

In the emergency room the patient first comes in contact with something he will be forced to live with for some days—the monitor. It will come to play an important role in his life, and it is at this point that its purpose should be most carefully and reassuringly explained. This should be done to avoid confusion or distorted ideas of its part in his treatment. A number of authors<sup>2,3,4</sup> have noted the range of patient's reactions to the monitor. Some feel that their lives are being maintained by the monitor and therefore become emotionally dependent on the machine. They may even have the fantasy that it is a mechanical heart and therefore fear its malfunction or failure. This extends in some cases to the point where patients may have severe emotional reactions on being transferred out of the CCU and expect to die when the leads are removed. Other patients come to see the monitor as a malevolent device which may at any time signal a deterioration in their condition. For them it becomes a sort of external, non-human judge

which is constantly evaluating them and their performance. For these patients, removal of the monitor is a source of reassurance and approval. They have passed the test. Although most patients on the surface appear to be relatively neutral to the monitor,<sup>3</sup> a careful explanation of its purpose when it is first used would do much to allay the anxiety of the patient and prevent distortions regarding its purpose and function.

### The Unit

Having read descriptions of many coronary care units and visited a number of others, it becomes clear that they are rarely designed for their purpose and generally are far from conducive to either comfort or good care. Hackett<sup>3</sup> describes the unit in his study as "a cramped, essentially windowless place, as cheerless and drab as a room in a tenement." One I visited was in the process of having a fire escape attached to the outer wall and was, therefore, about as quiet and peaceful as a construction site. Certainly others are better planned and appointed but most retain the multi-bed ward enabling patients to view each other, witness the emergencies of other patients and observe each other's monitors with all of the attendant potential for anxiety.

A typical CCU with its electronic equipment, constantly running intravenouses, bustling nursing staff, and constant change in patient population is often one of the most active units in any hospital. There is not only more activity but underlying this is the ever-present sense of potential emergency.

### Staff

Vreeland and Ellis<sup>5</sup> state that, when asked to identify the stresses placed upon them, most nurses promptly identify the effects on them of the patient's altered physiology, or the psychologic impact of his illness or his treatment. They basically identified the following sources of stress on the nursing staff: (1) the minute-to-minute, day-by-day contact with patients whose lives depend on them and therefore the increased sense of personal responsi-

bility, (2) the problems encountered in working with a complex array of electronic and other technical equipment, (3) maintaining smooth working relationships with other members of the health team, and (4) the constant awareness of the potential for emergencies.

My own data from a series of interviews carried out on the entire nursing staff of a coronary care unit support this. The nurses seem to be under significant stress and have few means by which to relieve the tension and frustration of their work. An additional source of tension for the nurses on a CCU (not specifically mentioned by Vreeland<sup>5</sup>) is the constant possibility of the need for cardiac resuscitation. Although by and large these were relatively young healthy women, the majority of those interviewed had considered the possibility of cardiac arrest occurring to them and whether or not they would wish resuscitation. Certainly, such concern would not generally occur to nursing staff on other units. In spite of all these stresses, however, I would agree that nurses who choose assignments on these units appear to gain greater gratification and sense of accomplishment than those who do not.

### The Patients

In sharp contrast to the staff, however, the patients are oddly passive and calm. The most obvious reason for this paradoxical patient response is the commonly described<sup>3 6 7</sup> denial on the part of the patient. This denial may take many forms. Croog<sup>6</sup> reports that 20 per cent deny ever having had a heart attack. Schroeder<sup>7</sup> found that 27 per cent did not remember ever having been in an intensive care unit. My own work shows that approximately one-third achieve complete psychologic withdrawal from the situation either by means of denial of the reality of their illness, by amnesia, or through total infantilism. Faced with a life-threatening cataclysmic event with which he cannot cope in any rational manner nor affect in any significant way, it is not surprising to discover that many patients find it necessary to deny the exist-

ence of such an event. We see this in other situations where reality is too overwhelming to be dealt with, such as in *Ulysses*, the death of a loved one, or natural disaster. In the CCU, many find it necessary to retreat into a total infant-like state where he simply eats, sleeps, and responds to stimuli, but has ceased to think. He becomes a baby who is cared for by adults. The fact that he is fed, bathed, denied choice, and is in fact treated as an infant permits and fosters this very primitive regression which in turn causes him to appear as a calm, passive individual when in fact he has actually ceased to be an adult in any sense of the word. Some studies have shown that the "denier" has a better prognosis than the "non-denier."

A second cause for this apparently relaxed attitude of the patients stems from the initial symptoms of the attack itself. The great apprehension and fear of death which heralds the onset of a myocardial infarction disappears as the pain diminishes. He no longer feels that he may die. The almost overwhelming premonition of death was not fulfilled. He has been granted a reprieve. Just as the initial fear of death is of vast proportion and difficult for anyone who has not experienced it to appreciate, so too, the relief afforded by the lifting of this fear is enormous. The patient frequently feels that he has survived, that it is all over and now he is safe. This sensation is akin to that felt by the individual who has a phobia about flying, when the plane touches down. The relief has an almost euphoric quality. It is as if now that it is over, nothing could go wrong.

Another factor which plays a role in the apparent serenity of coronary care patients (and one which has received surprisingly little notice) is again found in the basic description of the attack<sup>1</sup>—"severe weakness." From a previously active and robust individual the patient is abruptly reduced to a state of incredible weakness. As one patient put it, "the day before I played tennis; the day after I couldn't lift my head off the pillow." Thus, many patients are in a very real sense too



feeble and too sick to care. They do not have the strength to complain, to struggle, even to feel upset.

The last element in the apparent calm of the patient who has had a coronary which I will discuss is that of the cessation of psychologic conflict. The precoronary personality is one of tension, conflict, and pressure. This patient is often an over-achiever who lives with stress and who, at the time of his coronary, is often facing a significant conflict in his life. It may be a conscious or unconscious conflict but one which he is having difficulty totally resolving. Thus the stress builds and the infarction occurs. At this point he is removed from the world and placed in the womb of the CCU. He no longer has to strive, achieve, or compete. He is removed from a state of conflict and pressure and becomes simply a "patient." In this connection, it is interesting to note that a number of patients in the CCU are unable to discuss the future and many anticipate that it will be one of total invalidism.

Thus the denial of the illness and regression into infantilism, the sense of reprieve, the weakness, and the cessation of psychologic conflict all play a role in the apparent calm of many of the patients. All of these elements are not present in every case, nor are they often found in pure form, but a mixture of them may be observed in those patients whose response to their illness and the coronary care unit appears to be one of quiet acceptance. Also these factors help to explain the observations of others: "... occupants of coronary care are undercomplainers",<sup>3</sup> many patients are undersedated,<sup>8</sup> only six patients (out of 74) found the unit anxiety producing."<sup>4</sup> They may also aid in understanding the remarkable incident reported by Grace in his article, "Terror in the Coronary Care Unit."<sup>9</sup> "The man had been admitted to this 12 bed unit the previous day with the chief complaint of severe chest pain. At 7:30 a.m. the patient, shouting and obviously disoriented, rose from bed and began to terrorize the patients and personnel in the unit. He approached the women's beds, removed the

blankets and pulled at the patients' night clothes. He threatened the male patients and pushed their beds, all the while speaking in a loud, aggressive voice. He picked up a chair and, going from bed to bed and room to room, brandished it in the direction of the patients. He broke four large plate glass windows. He threatened the nurses, asked for knives so that he might kill the others and himself, and closed the door to one of the three-bed rooms and attempted to disrobe a female patient.

The nurses and the attendants on the floor were terrified. The physician on duty approached the patient, but he also was threatened with violence. Finally, four hospital security officers succeeded in "subduing" the patient in a room with three patients who had had recent acute myocardial infarctions. All twelve of the patients in the coronary care unit were directly exposed to this violent and threatening patient.

The episode ended shortly before 8 a.m. During all this time the electrocardiographic monitors were in operation. The electrocardiographic technician was observing at the monitor bank, as is our usual procedure. Although some slight increase in the heart rate was noted in all of the patients, no ventricular premature contractions or ectopic rhythms were observed or recorded. No ectopic beats or ectopic arrhythmias were noted at this time or during the rest of the day. But each of the physicians and nurses reported pounding in the chest during, and particularly immediately after, the excitement. All this suggests that the patients may have actually responded less to the threat than did the staff. The patients seemed, for the previously discussed reasons, relatively immune to anxiety.

I do not suggest that anxiety does not exist in CCU patients. Quite the opposite. Some patients are obviously and severely anxious. The level varies from that of moderate apprehension, to that of the individual who lies in bed in stark terror. Some are able openly to express their fears and concerns and thus receive the reassurance and/or sedation

they require. Too often the fears are masked by denial, by infantilism, or by withdrawal and therefore go unrecognized. The staff, physicians and nurses alike, should be alert to the great potential for covert or denied anxiety.

Among those factors (aside from the obvious threat of death) which may initiate or increase the level of apprehension are:

(a) The attitudes of the staff; their reactions to the patient and the illness.

(b) The presence of the mechanical and electronic equipment.

(c) The condition of other patients.

(d) The calls over the paging system for the cardiac emergency unit. I doubt whether any patient in a CCU is long in ignorance regarding the meaning of a "Code 9" or whatever euphemism is employed.

(e) Concern about the future and possible invalidism. This is greatly intensified by the severe physical and mental weakness that accompanies the attack. It is difficult for many patients to conceive that, given their present condition, they will ever again return to a productive, much less an active life.

A previously unreported source of anxiety is that regarding impotence. Following the severe physiologic and emotional trauma of a myocardial infarction most male patients are aware of being impotent. This is often feared as a permanent and shameful condition and is rarely discussed with the doctor. Thus, the patient may well go without the simple reassurance that would be so valuable to him. The very common occurrence of impotence during the early phase of the illness plays a role in the post-coronary patient's unwillingness or inability to resume sexual activity. Much of this difficulty could be avoided by frank and open discussion between doctor and patient. All too often the physician assumes that the patient possesses a level of knowledge which he simply does not have.

Three basic factors are involved in the psychologic effects of a CCU. First, there is the staff, medical and nursing, and the stresses placed upon them by the patients and the unit itself. Second, there are the patients with their defenses or lack of defenses against this cataclysmic event (both physiologically and psychologically), which has interrupted their lives. Third, there is the physical unit itself with all of its advantages and limitations which will in turn affect both staff and patient. The interplay of these three factors determines the form as well as the intensity of the psychologic pressures both individually and on the unit as a whole. Certain simple recommendations may be made regarding each of the three.

It is important that lines of communication be maintained between the medical and nursing staff as well as between the staff and the patients. Those on a coronary care unit should be recognized not only for their superior skills but for the considerable stress which inevitably is placed upon them. In addition, they should be afforded greater periods of relief time during the day to permit release of tension and dilution of anxiety.

Nurses and physicians should be aware of both the fears and the defenses of patients and learn to deal with them appropriately. Patients should be reassured about the electronic equipment, emergencies on the unit, the severe weakness experienced, and so on. They should be encouraged to ask questions and ventilate any anxieties. The possibility of undersedation should be kept in mind.

The unit itself should be comprised of private rooms or, at the very least, patients should be screened from each other by permanent partitions so that direct observation of other patients or of the monitors is not possible. The unit should be as bright and cheerful as possible, and should include windows so as to maintain the patient's sense of reality and time. Some low level of external stimulation such as reading or listening to the radio should be permitted to those patients who wish it, for the same reason. And cer-

tainly the unit should be located in a truly quiet section of the hospital.

Given the above, patients will receive proper care and neither the unit nor the staff will contribute to the anxiety of the patients. The overtly frightened individual will be counseled and/or sedated. The covertly upset patient will be recognized and cared for and the one who is regressed or denying will be permitted to do so. There appears to be no justification for attempting to alter either the infantilism or denial seen on a CCU. These defenses are used by the patient because he requires them at that time. They serve their purposes well, as is evidenced by the fact that the so-called "denier" has a lower mortality rate. In this regard one should follow the basic axiom of psychotherapy: never remove

a defense unless you have something better to offer in its place.

## Bibliography

1. Cecil, R. and Loeb, R.: *A Textbook of Medicine*, 8th Ed. Saunders, Philadelphia, 1951
2. Bishop, L. F. and Reichert, P.: *Psychosomatics*, 10:189 (1969)
3. Hackett, T. P., Cassem, N. H., and Wishnie, H. A.: *New Eng. J. Med.*, 70:1365 (1968)
4. Dominian, J. and Dobson, M.: *Brit. Med. J.*, 4:795 (1969)
5. Vreeland, R. and Ellis, G. L.: *JAMA*, 208:322 (1969)
6. Croog, S. H., Shapiro, D. S., and Levine, S.: *Psychosom. Med.*, 33:385 (1971)
7. Schroeder, H. G.: *Anesthesia*, 26:28 (1971)
8. Hackett, T. P., Cassem, N. H., and Wishnie, H. A.: *Am. Heart J.*, 78:727 (1969)
9. Grace, W. J.: *Am. J. Cardiol.*, 22:746 (1968)

208 Anderson Street

## Narcotic Antagonist Being Evaluated

Testing of a chemical which has shown promise in the treatment of heroin addiction will be speeded as a result of an agreement by HEW's National Institute of Mental Health and Sterling Drug, Inc. The drug company will provide a free supply of "cyclazocine" to the Institute for distribution to qualified investigators for testing of the drug's effectiveness in treating addicts.

The National Institute of Mental Health and the White House Special Action Office for Drug Abuse Prevention have jointly launched a major research program hoping to find and perfect one or more "narcotic antagonists," such as cyclazocine. The Director of NIMH pointed out that, "This is an outstanding example of a pharmaceutical company participating in the effort to combat drug problems."

Sterling Drug has also offered to give NIMH a royalty-free license to have cyclazocine manufactured for use in government treatment

programs, should tests prove the drug's value in addiction therapy. This firm holds the patent on cyclazocine, which has been found in animal studies and limited clinical testing to have potential as a narcotic antagonist to block the effects of heroin in the body. Present drawbacks to the use of cyclazocine include its relative short duration of action—approximately 24 hours—and some undesirable side effects, such as nausea, dizziness, and sometimes hallucinations. Additional research and testing is aimed at prolonging the drug's duration of action, possibly through the use of a biodegradable vehicle which would release the chemical slowly, and at reducing or preventing its side effects.

NIMH has awarded more than \$2 million in contracts for work on a series of narcotic antagonists, including cyclazocine, and is continuing to provide grant support for a variety of studies related to the search for effective compounds to treat heroin addiction.



## ALL IN HIS HEAD:

Watery Eyes

Nasal  
Congestion

Sneezing

Runny Nose

**THE COLD  
SYMPTOMS  
THAT  
MAKE HIM  
MISERABLE**

## ALL IN 'ORNADE:

Drying Agent  
(isopropamide,  
as the iodide—  
2.5 mg.)

Decongestant  
(phenylpropanol-  
amine HCl—50 mg.)

Antihistamine  
(chlorpheniramine  
maleate—8 mg.)

**THE  
INGREDIENTS  
HE NEEDS  
FOR PROLONGED  
RELIEF**

Before prescribing, see complete prescribing information in SK&F literature or PDR.

**Indications:** Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis, vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

**Contraindications:** Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

**Warnings:** Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

**Usage in Pregnancy:** In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

**Effect on PBI Determination and  $I^{131}$  Uptake.** Isopropamide iodide may alter PBI test results and will suppress  $I^{131}$  uptake. Substitute thyroid tests unaffected by exogenous iodides.

**Precautions:** Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

**Adverse Reactions:** Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

**Supplied:** Bottles of 50 capsules.

SK&F Smith Kline & French Laboratories

Trademark

# ORNADE® SPANSULE®

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

brand of sustained release capsules

## UNCOMMON RELIEF FOR COLD SYMPTOMS

# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg. -estrogen O.C. (such as **Demulen<sup>®</sup>**).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E<sup>®</sup>**).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen<sup>®</sup>**).

Age 21, short, mammosome, with normal menses, some acne. Was put on pre-nuptial regimen of 50-mcg. -estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg. -estrogen combination (such as **Enovid-E<sup>®</sup>** or a sequential).





Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

\*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. has recurrent trichomoniasis and Monilia.

Indicates estrogen deficiency and excess of progestogen in current O.C.

1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E\*** or **Ovulen\*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.

Indicates probable need for more estrogen.

1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen\***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.

Indicates probable progestogen excess.

1st choice: Switch to a center-spectrum pill (such as **Ovulen\***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.

Indicates probable excess of estrogen.

1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen\***).

**Ovulen®** a balanced center-spectrum O.C. for most

Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

**Demulen®** a moderately progestogen-dominant O.C. for many

Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients. Both Ovulen and Demulen are available in 21- and 28-pill schedules.

SEARLE

Products of SEARLE & CO.  
San Juan, Puerto Rico 00936

**Enovid-E®** a moderately estrogen-dominant O.C. for some

Each tablet contains norethynodrel 2.5 mg./mestranol 0.1 mg.

SEARLE

Product of Searle Laboratories Division  
G.D. SEARLE & CO.  
P.O. Box 5110, Chicago, Illinois 60680  
Where "The Pill" Began

For a brief summary of prescribing information, please see next page.



a family of O.C. products to help you match  
the right pill to the right patient

# Ovulen®

Each white tablet contains  
ethynodiol diacetate 1 mg / mestranol 0.1 mg.

# Demulen®

Each white tablet contains  
ethynodiol diacetate 1 mg / ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function, increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X, thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values, metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P. Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R. Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E. Thromboembolism and Oral Contraceptives. An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov) 1969.

SEARLE

Products of SEARLE & CO.  
San Juan, Puerto Rico 00936

# Enovid-E®

norethynodrel 2.5 mg / mestranol 0.1 mg

**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The Special Note, Contraindications, Warnings, Precautions and Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

## Enovid-E®

brand of norethynodrel with mestranol

SEARLE

Product of Searle Laboratories Division  
G. D. SEARLE & CO.  
P.O. Box 5110, Chicago, Illinois 60680  
Where "The Pill" Began

*It is unusual to make a study to determine wrong diagnoses, but here is such a review with some practical pointers on avoiding the errors.*

# Erroneous Diagnoses on Admission of Chest Cases\*

## A Pattern of Care Study

**Samuel Cohen, M.D., and  
Rolando M. Bueno, M.D./Jersey City**

The presence within the department of medicine of the Pollak Hospital of a tuberculosis unit and an adult general medical unit provides a constant diagnostic medical challenge in trying to decide which patients with chest diseases on admission belong to which service. It seemed to us advantageous to determine the pitfalls in erroneous diagnoses on admission of chest cases and the length of stay in the respective services before transfer was effected.

### Findings

All of the data mentioned below apply to the two year period 1970-1972, inclusive. We had 374 admissions in the tuberculosis unit (hereafter referred to as group 1) and 953 admissions on the general medical floor (hereafter referred to as group 2).

In group 1, some 26 cases or 7 per cent were misdiagnosed on admission and subsequently shown to have non-tuberculous chest disease as the dominant clinical condition. Four of them were later discharged directly from the hospital and the remainder were transferred to the general medical floor. In group 2, we found 11 erroneous admissions (only 1 per cent of the total). These patients were then transferred to the tuberculosis unit.

The length of stay of the 26 patients in group 1 prior to transfer or direct discharge varied from 1 to 44 days with an average of 15 days.

The comparable figures for the eleven patients in group 2 were 1 to 40 days and 10 days, respectively.

Sources of admission were obtained for both categories: 65 per cent (17 cases) of the 26 cases in group 1 were admitted from the hospital chest clinic in contrast to 27 per cent (3 cases out of 11) derived from the same source for group 2; the remaining patients in both groups were admitted by private physicians or as transfers from other hospitals.

Of the 26 cases misdiagnosed as tuberculosis on admission, 8 (30 per cent) had been diagnosed *previously* as tuberculosis. On readmission in 1970 or 1971, this disease was *inactive* or *quiescent* and the patients were readmitted to the tuberculosis unit with *associated dominant clinical non-tuberculous conditions*. These included carcinoma of lung (three), plus one each: carcinoma of the esophagus with pulmonary metastasis, pulmonary abscess, pneumonitis, arteriosclerotic heart disease with failure and pleura effusion, and arteriosclerotic heart disease with pulmonary emphysema. Final diagnoses in the remaining 18 cases were primary carcinoma of lung, two; metastatic cancer of lung, one; pulmonary abscess, two; necrotizing pneumonia, two; pneumonitis, three; bronchiectasis, one; sarcoidosis, two; possible sarcoidosis, one; berylliosis, one;

\*This study is from the B. S. Pollak Hospital for Chest Diseases in Jersey City where Dr. Cohen is Director of Medicine and Medical Director of the hospital, and Dr. Bueno is House Physician in the Department of Medicine.



post-radiation pulmonary fibrosis, one; recurrent pericarditis, one; and rheumatoid arthritis, one.

Of the eleven cases admitted to the general medical floor and later diagnosed as tuberculosis, the admitting diagnoses were one each: chronic bronchitis, psittacosis, pulmonary infarction, pneumonitis, empyema, post-gastrectomy syndrome, bronchiectasis, pleural effusion (etiology undetermined), and pulmonary abscess, and two cases of necrotizing pneumonia.

It is thus seen that a rather wide spectrum of interesting differential diagnostic problems presented themselves.

### Comments

The desirability for an accurate clinical impression presents a constant medical challenge in the allocation of patients on admission to a tuberculosis unit or general medical service. In a two-year review, the error was considerably greater in diagnosing pulmonary tuberculosis for other non-tuberculous chest conditions on admission than the reverse (7 per cent in the former compared to one per cent in the latter group).

To achieve even greater accuracy, one should keep in mind such items as: (a) a more thorough review of the patient's clinic records, x-rays, and sputum reports; (b) close attention to the history—is the onset of the present illness acute? foul sputum? hemoptysis? persistent chest pain? enlarged heart, cardiac failure, arrhythmia? local or constitutional symptoms referable to other organ systems? and occupational and smoking history; (c) a patient with *known controlled pulmonary tuberculosis* may develop a non-tuberculous pneumonia or lung abscess or carcinoma or other intrathoracic disability, and so on. Thirty per cent of the misdiagnoses were in this category. As effective chemotherapy and surgery have prolonged their lives, many tuberculosis patients now contract or die from non-tuberculous conditions. However, *active* pulmonary tuberculosis may coexist with associ-

ated carcinoma or pulmonary abscess or necrotizing pneumonia (due, for example, to the staphylococcus or Friedlander's bacillus) producing breakdown of pre-existing inactive tuberculous foci. And, of course, a patient may develop tuberculosis who had been previously treated for a non-tuberculous pulmonary process.

X-ray findings should be correlated with the history and physical examination for proper diagnostic evaluation. Not every radiologic abnormality in the upper lung fields is tuberculosis (a common source of error); viral or bacterial and, in particular, necrotizing pneumonia with areas of air and fluid level (such as pneumatoceles) may be mistaken for cavitary tuberculosis. Tuberculosis, in turn, can mimic these conditions. Tuberculosis can occur in the lower lobes also.

After admission to the hospital, aggressive attempts should be made to resolve the differential diagnosis when in doubt.

A healthy skepticism and good clinical intuition are helpful. Be wary of positive gastric washings report for acid fast bacilli. In our institution we have not used gastric lavage for many years but collect sputum by the superheated aerosol method employing propylene glycol. Sputum smear reports with one or two organisms or positive sputum cultures with one colony should be viewed with suspicion. Seek confirmation of such reports. Also, use the intracutaneous Mantoux (five tuberculin unit) test instead of the Tine test and see for yourself whether it is negative or positive.

In the differential diagnosis between tuberculous and non-tuberculous pneumonia, it is best to obtain sputum examinations for tubercle bacilli and pyogens first (and sensitivity studies), then start the patient on a broad spectrum antibiotic. Re-x-ray the patient at about seven to ten day intervals to determine the rate and extent of resolution, if any. The *simultaneous* administration of broad spectrum and tuberculous antibiotics more often leads to confusion than clarification.



Use other ancillary aids, when indicated, particularly cytologic examinations of the sputum, bronchoscopy, lymph node biopsy, thoracentesis, and so on. Make proper transfer disposition as soon as possible.

The combined average length of stay for all

of the misdiagnosed cases in this review was fifteen days for group 1 and ten days for group 2. This, we believe, represents good clinical alertness on the part of the physicians rendering in-patient care. We shall never achieve perfection but we can always try to become less imperfect.

100 Clifton Place

Rating Pollutants

Dr. Howard Reiquam, senior meteorologist at the Battelle Memorial Institute in Columbus, Ohio, has developed a rating scale for all the pollutants abroad in the world.

Three scales enter into the formula—one, a *persistence scale* in which one point is given if the effect lasts for days, two if it lasts for months, three if it lasts for years, four if it lasts for decades, and five if it lasts for centuries. Two, a *range scale*—one point if the effects are felt only locally, two, if the effects are regional, three, if continental, four, if intercontinental, and five, if global. Three, a *complexity scale*—which is definitely abstract. A pollution problem in this scale is given one point for each of any of nine possible areas in which it may have an effect. These are biologic, social, political, air, land, water, energy, nutrition, and materials.

After a pollutant has been weighed in these three scales, the results are multiplied one by another to arrive at the index of pollution. Thus, taking pesticides as an example: *Persistence* is rated 4 because they can last for decades, *Range* is rated 5 because their use is global, and *Complexity* is rated 7 because they have biologic effects, social and political ramifications, involve air, land, and water, and affect sources of nutrition—4 x 5 x 7 = 140.

According to this formula the ranking indices of pollutants are as follows:

1. Pesticides .....	140
2. Heavy metals such as mercury .....	90
3. Carbon dioxide .....	75
4. Sulfur dioxide .....	72

5. Suspended particulates in air .....	72
6. Oil spills .....	48
7. Waterborne industrial wastes .....	48
8. Solid waste .....	35
9. Chemical fertilizer .....	30
10. Organic sewage .....	24
11. Oxides of nitrogen .....	24
12. Storable radioactive wastes .....	20
13. Tritium and krypton-85 (radioactive particles lost into air and water) .....	20
14. Litter .....	16
15. Photochemical oxidants (smog) .....	12
16. Hydrocarbons in air .....	10
17. Carbon monoxide .....	9
18. Thermal pollution .....	5
19. Community noise .....	4

This ranking will not remain static. Priorities can change drastically in the future. At least four pollutants are likely to move rapidly to the forefront. Because solid waste disposal problems will become more widespread, it is possible they may move up from eighth to second place. The threat of radioactive particles emitted into the air and water by nuclear power plants may rise from fourteenth place to third. Technology has so far been able to keep ahead of this. For the same reason waste heat from these plants could boost thermal pollution from eighteenth place to ninth. Pesticides, however, are expected to fall from first place to fifteenth as a result of eliminating the most persistent chemicals. This will leave in high priority the heavy metals of which mercury is the best known at the present time.

Individuals, communities, states, nations, and continents are all involved. We are beginning to understand the problem at long last and that puts us in the path toward solutions.

—From the May 1, 1972, New York State Journal of Medicine.



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, periodic tremors and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Valium® (diazepam)

To help you manage excessive psychic tension



"...a more satisfactory treatment..."<sup>1</sup>



# VITAMIN C

## MICRO-DIALYSIS SUSTAINED RELEASE

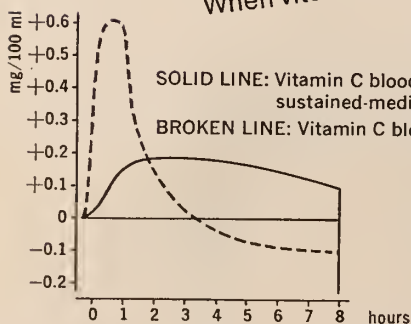
500 mg. CAPSULES

# CEVI-BID

CEVI-BID Capsules permit convenient, b.i.d. dosage for more predictable, sustained vitamin C blood levels all day and night. This avoids the "peaks and valleys" that result from ordinary vitamin C intake (wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels). The unpredictability of enteric-coated vitamin C is also avoided. Cevi-Bid's unique micro-dialysis principle provides release of 500 mg. of vitamin C during a 12 hour period at a smooth, uniform rate.

"This method [CEVI-BID] provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."<sup>1</sup>

When vitamin C is indicated... prescribe CEVI-BID.



SOLID LINE: Vitamin C blood levels obtained with sustained-medication capsules (CEVI-BID).  
BROKEN LINE: Vitamin C blood levels obtained with tablets.

Samples on Request  
**GERIATRIC PHARMACEUTICAL CORP.**  
Floral Park, N.Y. 11001  
Pioneers in Geriatric Research



\* Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules).  
\*Adaptation

<sup>1</sup> Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

DEVELOPERS OF GER-O-FOAM • GAYSAL • TESTAND-B

*Never before have we published a paper by a Nigerian author. This article reminds us of the problems of foreign physicians in the USA.*

# Understanding African Students in the United States

---

**Amechi Anumonye/Lagos, Nigeria\***

During my two years as an African psychiatrist in the United States, my help has been requested in dealing with some African and Asian students who have had emotional problems. I have realized that American people in general are not well informed about Africa and African students. This paper is offered in the hope of elucidating some of the poorly explored regions in the life of African students overseas.

Psychosocial<sup>1</sup> and psychiatric studies<sup>2</sup> on foreign students in Britain and America have mentioned African students<sup>3</sup> usually globally and referring to several cultural groups. The problems arising from such global generalizations have been stressed. Most of the earlier studies were retrospective and presented many problems of interpretation. This paper deals with a project undertaken solely to investigate a specific group of African students living in a British university city (a) to illustrate the students' major characteristics, (b) to outline the psychological stresses to which they were exposed and, (c) to examine their degree of adaptation or social adjustment, all very important for preventive psychiatry.

Findings on Africans are compared with those on Asians,<sup>4</sup> emphasizing the contribution of such a study towards the understanding of factors important in anticipatory guidance, in prevention of psychiatric disorder, and in crises intervention for African students in alien Western cultures. This be-

comes increasingly important as the tendency towards American education increases due to improved international cooperation.

## Method of Study

One hundred fifty Nigerian students served as subjects in the study which ended in Edinburgh (Scotland), in 1969. Demographic and socio-economic data were obtained with a structured interview schedule. Emotional stresses and the students' attitudes to Britain were studied in a way very similar to that used by Singh<sup>4</sup> on Indian students to obtain some meaningful comparison between African and these Asian students.

Apart from descriptive data relating to the students and the associated cultural and situational factors, several pertinent hypotheses were examined. The measures of emotional stress, academic stress, financial stress, and adaptation (or social adjustment) were similar to those on Indian students; their derivation and scoring are detailed in the author's book, *African Students in Alien Cultures*.<sup>4</sup>

## Findings and Discussion

Nigerian students in Edinburgh had passed their adolescence, and were older than the British undergraduate equivalent but less so at the postgraduate level. Similar characteristics exist in the U.S. The students were predominantly Yorubas and Ibos. This rep-

---

\*The author is Senior Lecturer in Psychiatry at the Medical College of the University of Lagos, Lagos, Nigeria. He was, for two years, Director of Psychiatry at the Martland Hospital in Newark, New Jersey.

resented the true picture of literacy in Nigeria at the time of the study.

There were more postgraduates than undergraduates; ratio 4 to 1; a factor affecting age and sex distributions. There were twice as many males as females. Many of the males were separated from their wives by their being overseas. The number of single females was small. This is comparable to the U.S. picture.

TABLE 1  
*Age Distribution of Students According To Sex*

<i>Age in Years</i>	<i>Males</i>		<i>Females</i>		<i>Total</i>
	<i>Married</i>	<i>Single</i>	<i>Married</i>	<i>Single</i>	
21-25	0	12	8	6	26
26-30	16	20	17	4	57
31-35	14	18	9	2	43
Over 35	14	2	7	1	24
Total	44	52	41	13	150

The facilities in which Nigerian students studied were very few, probably because Edinburgh had a limited number of university and similar institutions. Two facilities in which Nigerian students were usually interested in places like London (i.e. law and teacher-training) were not satisfactory for Nigerian needs in the form they exist in Scotland. The situation is the same in America, but more facilities are available.

Data on the students' parents were interesting, though reliability is open to question. Close scrutiny of personal matters is often resisted by many Nigerians. We found (a) social class stratification difficult, (b) parental social class not always the same as the students, and (c) the extended family system very powerful.

Many parents were in the "lower income groups"; 38 per cent had little or no education, 50 per cent had primary education only, 12 per cent secondary and over. The students were predominantly in the first generation having a university education. Many families were polygamous, the fathers authoritarian, and the student often the child on whom a lot depended.

The distribution of sibling ranking and sex is interesting; the interpretation is difficult.

The female child takes a second place in most families. Many of the girls in this study were overseas on the auspices of their husbands or other relative, a phenomenon not uncommon in the USA.

Nigerian students (85 per cent) had lived away from home during grammar school days, usually studying in boarding schools. Many parents lived in rural areas, but 60 per cent of the students were from urban schools. Separation from family is usually not so traumatic although separation from the culture is and social isolation can occur.

Many Nigerian postgraduates (unlike the British) had some recognizable social status—usually of the Registrar General Social Class 11. With the establishment of the Nigerian universities (and because of the selective nature of the postgraduate facilities open to Nigerians in Edinburgh) many of the Nigerians were in medicine (57 per cent). This is dissimilar to the USA where many Africans often begin their training.

Westernization was low in the immediate family of the students, but not so when the "extended family" was examined. This probably illustrates the self-selected nature of the students in Edinburgh; only those Nigerians who could survive without needing a job went to Edinburgh. The poor Nigerian students seen in industrial areas were absent, emphasizing one significance of the "larger family" for students overseas, a phenomenon of importance in stress production. The attraction to the American system of life (where students often *can* work) is very great.

Nigerian students were very ethnocentric. This had occasioned considerable controversy. It limits not only intertribal intimate friendship relationship, but also intertribal marriage tendencies and is of political importance as well as of pathoplastic and psychological significance in stress production. It limits interaction with the host too.

The typical working wife was missing in Ed-



inburgh. Several factors contributed to the fact that the male students did not depend on their wives, as observed in London and similar cities: (a) Edinburgh lacks industries, being itself predominantly a university center; (b) there is apparent discrimination, more obvious against "colored" female workers than against the male because many of such jobs for the female require face-to-face contact with the general population and, according to PEP Report<sup>5</sup>, employers do not give these to "colored" people; (c) most Nigerian women in Edinburgh had academic credentials satisfactory for further education in Edinburgh; and (d) the husbands were frequently scholarship holders or doctors whose stipends were guaranteed. Both husband and wife tend to be gainfully employed in America whenever this is possible.

The background sociocultural factors predisposing to emotional stress overseas include:

(a) the absence of the gregarious family and similar social conditions and (b) being the first-born child and being supported financially overseas by a large local community. Areas of stress expressed by students were: (1) separation from spouse; (2) coming from rural parental home; (3) coming from large parental home; (4) coming from polygamous home; (5) having large number of siblings; and (6) being primary or intermediate sibling.

To the Nigerian married woman, child bearing has multiple significance. It is a confirmation of "being female," and insures the woman to whom polygamy is not taboo that she, the first wife, has also the first child. Some stress factors associated with the student's wife are illustrated in Table 2.

Leaving children with "nannies," baby-sitters, or with foster parents was preferred to "artificial sterility," because the ability to procreate must be established. This is enhanced by the socio-cultural fact that in Africa the extended family cared for children.

The apparent possessiveness peculiar to British parent-child relationship is alien to Afri-

TABLE 2  
*Stress Factors Arising in Relation To Student's Wife*

<i>Factors Considered</i>	<i>No. of Wives</i>
1. Separation from spouse	15 (37%)
absent spouse in Nigeria	9
absent spouse in Britain	6
2. Wife concurrently a student	30 (73%)
3. Wife of lower academic status	7 (17%)
4. Wife predominantly left lonely	25 (66%)
5. Childless marriage over 3 years	5 (12%)
6. Wife in regular employment	26 (63%)
7. Wife in comparatively menial job	11 (27%)
8. Expartraite wife	5 (12%)
(forced marriage)	4
lower social class	3
low academic status)	3

cans. The seeming dislike for children often perceived in, "Room to Let: No Child, No Dog," occasions much amusement. African students do not understand why landladies equate children with dogs! This again is different in the USA where the African students' pattern of life is similar to the American in this area. The cost of baby-sitters is, however, prohibitive.

Situational factors include (a) social life, (b) personal problems, and (c) academic adjustment.

### Social Life

Difficulties relating to accommodation predominated. Student hostel accommodation is limited in Edinburgh. Like most overseas students, Nigerians preferred "digs" (private rooms) which (a) were cheaper, (b) enabled them to cook their own meals, and (c) allowed an atmosphere of a "home away from home." Hotel accommodation is expensive and inconvenient. This is similar to observations in the USA. The University had a long waiting list and was unable to provide enough help. Besides, this Department had the support of less than 40 per cent of Edinburgh landladies, the rest of whom barred colored students. This lights up the prime reason for accommodation difficulties, apart from the general scarcity: color discrimination. Sociologic studies on foreign colored students had dealt extensively with this phenomenon, and it was not my intention further to investigate this. Nigerian students, like other overseas minority groups, cluster into "acceptable" and accepting quarters. This is

of therapeutic importance although on a large scale in other circumstances, it has been blamed for immigrant "ghettos" and poor contact with host population.

A low declaration of color discrimination was observed among Nigerian students in contrast to the high declaration attributed to Indians.<sup>4</sup> This is seen as a peculiarity of the Nigerians as well as that of the city of Edinburgh. The absence of labor problems and the fact that Nigerians in Edinburgh were mainly in the University and in the medical or allied professions had obviously mitigated this stressful phenomenon. A social distance was observed between the Scottish people and many of their overseas guests. In spite of the associated disadvantages this had a conflict-reducing value. American color problems affect Africans in a different way.

Minimal intimate friendship existed between the foreign students and the hosts (though culture bias was low on both sides). Major reasons offered were (a) cultural differences in world views; (b) British insularity; (c) pressure of students' academic work (d) language difficulties; (e) the stresses of urban life; and (f) the temporary nature of overseas students' stay. All these determine the lack of enthusiasm for and the inadequate need for closer contact than mere classroom acquaintance, and the artificial mutual sexual relationship peculiar to the deprived.

Private visits to British families were not common. Group visits to families (arranged by voluntary organizations) often achieved very little, being of doubtful value in improving relationships—an area of difficulty for those African students and other "colored" overseas immigrants who had often striven to identify with the host. There was some belief that African students receive preferential treatment from American whites and this estranges them from black American colleagues.

The Nigerian students' range of activities overseas exhibited a shrinkage, similar to that of the Indians. Unlike the Indian, who with-

drew into individual activities, the Nigerian usually participated actively in weekend parties organized by West Indian and African students. Such group activities served multiple purposes; sexual, social, and psychotherapeutic. The same process takes place in the USA.

### Personal Problems

Inadequate and unintegrated social life of Indian students in Britain was alleged to cause much emotional stress: loneliness, homesickness, and psychological depression. Inadequate social life was accepted as significant by Nigerians; the importance of segregation was questioned.

Only a small number of Nigerians could live in hotels and boarding houses. Halls of residence and hostels were limited. Living as paying guests caused emotional difficulties. This problem is the same in the USA. Living away from home for the first time (very important to Indians) had hardly any significance in our study. Most Nigerians had lived away from home in boarding schools before visiting Britain.

Dietary differences as a source of worries were not important; there were no strict religious food-taboos among the Southern Nigerians. Enforced vegetarian diets were not common. Nigerians often regard salads and many British diets as essentially vegetarian. They preferred to prepare their own meals, having access to the necessary ingredients. In the USA, Nigerian staple diets are similar to those of the Puerto Rican, the Haitian, and the West Indians and the foodstuffs are easily available.

### Financial Stress

Situational and cultural factors affected the students' finances. Even the students who had come on a scholarship were not exempt from financial stress. Scholarship monies were never enough for all the essential needs of the students. Many of the students had considerable financial responsibilities, before leaving

Nigeria. Many scholarships and fellowships did not provide for the students' immediate family, often being based by foreign benefactors on the cultural background of the European or American recipients who belong essentially to the nuclear rather than the extended family.

For those students who had come on the auspices of the larger family, the stress was also great. The hosts' cost of living is several times higher than the Nigerian. Many students on private sponsorship spend a great deal of the resources of the larger family at home.

When, in order to economize, the student leaves his wife and children in Africa while he goes overseas, this creates further problems. The extended family at home had not only to maintain the student but also had the burden of his immediate dependents.

### Academic Adjustment

Here the Nigerian differs from the Asian. Many of the Indian postgraduates were said<sup>6</sup> to be inadequately prepared for their desired level of study, unlike Nigerians who invariably held British or very comparable undergraduate diplomas. The lack of originality and critical attitude in studying attributed to Indian students (for the same reason) does not seem to apply to Nigerians. The differences between American and British (and therefore Nigerian) methods of study can be stress-producing. Language problems arising in relation to academic pursuits were minimal. Technical language in academic studies does not entail intrapsychic communication necessary for human relationships; this is where foreigners to any culture suffer most.

Excessive deferential attitude to teachers observed among Asians was absent among Nigerian students in Edinburgh; this finding is of interest because in Nigerian social relationships, the seniority principle is very strong among all classes. Why it has not extended into the academic (teacher-student) relationships is not clear.

### Cultural Factors

Information of great value was obtained here: cultural bias in the perception and the interpretation (or misinterpretation) of phenomena in an alien culture richly illustrated. Like Indian students, Nigerians used Nigerian norms in assessing the British. Nigerian students perceived British cultural phenomena differently from the way the Indians did; they, also like Indians, were very conscious of differences between them and the British. Indians rated Indians as higher than the British in individual behavior. Nigerians did the same. Indians rated the British as higher than Indians in social behavior. Nigerian students were more critical of the British social behavior. Africans do not approve of much of the American aggressiveness. Nigerian students had similar views, about British social institutions, to Indian students' especially in relation to family system and to religion. Nigerians disapproved of the British parent-child relationship. Religion was seen as very superficial in Britain and its meaning destroyed by materialism.

### Social Class: Academic Status

Parental social background of Nigerian students could not be used to assess the social class of the students. The nearest stratification applicable was academic status.

In many areas of this study the postgraduate did not differ significantly from the undergraduate. Where they did differ several other factors were operating simultaneously making definite statements regarding academic status difficult or at least dubious.

Many postgraduates were older than the undergraduates, were married, and some were living without their wives. They were often more urbanized but not necessarily more westernized. Postgraduates stayed shorter periods than undergraduates and had fewer academic problems, but had similar preferences for residential areas and for type of accommodation, diets, and friendships. This is not the same in the USA where most Nigerians go from undergraduate to graduate



studies. The forces impelling postgraduates toward overseas education are no less stressful than for the undergraduates. Quite often both are in the first generation receiving overseas education in their local communities and expecting similar social mobilities.

Although the postgraduate has greater financial stress having to provide for himself and "many dependents," for many undergraduates this problem also exists since they had held some jobs before going overseas. Nigerian parents often feel—and probably rightly too—that having worked before going overseas, their sons and daughters would appreciate money better. While this may be true, there is no evidence that it is to the best interest of the student. This intensifies the African students' need to work while studying overseas.

The immediate effect of the reduction in social status which inevitably associates with going overseas after holding some responsible position at home is of importance for anticipatory guidance and preventive medicine.

### Summary

150 Nigerian students (predominantly in medical and allied fields) were studied for

University of Lagos College of Medicine

demographic data, psychosocial stresses, and adaptation (or social adjustment) in Edinburgh, Scotland. A comparison was made with findings by previous workers on Indian students and with the Africans in the USA.

The findings on these students illustrate factors associated with psychological stress overseas. These data will be useful for prevention and crises intervention. It is hoped that findings on Nigerians can be meaningfully extended to most African students overseas.

This study was done when I was a Research Fellow in Social Psychiatry at the University Department of Psychiatry in Edinburgh under the auspices of the Rockefeller Foundation. I wish to thank Professor G. M. Carstairs, Department Head, and Dr. Henry Walton, Senior Lecturer and Consultant Psychiatrist in the Department, for their support in many ways, as well as other colleagues without whose help this study would have been impossible.

### References

1. PEP Report, Colonial Students in Britain, London (1955)
2. Carey, A. T.: The Social Adaptation of Colonial Students in London, Ph. D. Thesis, Edinburgh University (1955)
3. Lambo, T. A.: Social and health problems of Nigerian students in Britain and Ireland. Government Printer, Western Region Nigeria (1959)
4. Anumonye, A.: *African Students in Alien Cultures*. Buffalo, New York, Black Academy Press (1970)
5. PEP Report, Racial Discrimination, London (1967)

### Telephone Consultation Service

Physicians confronted with a clinical problem can now obtain medical consultation over the telephone. The *Physicians' Telephone Consultation Service* provides telephone consultation to all doctors who need help when a patient is difficult to diagnose and treat. Authorities are available at all hours to give assistance over the telephone. The appropriate specialist will be called by the service center in Chicago while the inquiring physician is on the phone. The call will be con-

nected so that the physician may talk directly to the specialist. If, however, the inquiring physician is unable to furnish the consultant with sufficient information to permit him to make recommendations, the inquiring doctor will be advised to send the patient to a medical center for the necessary tests. This new service will provide a means by which physician may take advantage of the most advanced forms of treatment merely by calling the Chicago office—(312) 782-7888.

*Are we doing too many T and A operations, or, perhaps, not enough? Here is a thought-provoking contribution with some non-dogmatic answers.*

# Symposium on Tonsillectomy-Adenoidectomy and Otitis Media

---

**William L. Wood, M.D. and  
Robert I. Oberhand, M.D./Red Bank**

The role of tonsillectomy and adenoidectomy in the management of children with upper respiratory problems is in need of comprehensive review and re-evaluation. Although we would like to believe that every member of the medical community carefully and judiciously evaluates each patient's problems and plans therapy accordingly, this unfortunately is not true. The full spectrum of attitudes exists. On the one hand are those who will indiscriminately operate. At the other end of the spectrum are those physicians who, as extensions of the mother's ego, will, at all costs, protect "their" child from the "mutilating" knife of the surgeon. Somewhere in between these extremes lies a rational plan of evaluation and treatment. This paper will attempt broadly to define sensible guidelines for the management of recurrent respiratory problems in the pediatric age group, with special reference to the allergic child.

## **Tonsillectomy**

Indications for tonsillectomy and adenoidectomy are different, and the "incidental" removal of tonsils during adenoidectomy should not be approved. The selection of patients for tonsillectomy might be approached by priority in relation to the infectious afflictions. The only absolute indication for tonsillectomy is the occurrence of a peritonsillar abscess. This condition recurs, and the morbidity includes

the frequently fatal complications of parapharyngeal abscess, hemorrhage, and pulmonary abscess.

Persistent pyrexial tonsillitis, accompanied by streptococcal-related entities and frequent or severe tonsillitis over several years, four or more a fall-winter season, despite adequate management, would suggest high priority.

"Kissing tonsils" causing symptoms of dysphagia or guttural speech should be removed.

In children with rheumatic heart disease, the cardiologist should make the choice regarding surgery. The same indications exist for this group, and the routine performance of tonsillectomy in asymptomatic children is not indicated.

The largest group is by far the least specific. The child is referred with a history of frequent sore throats, with or without tonsillitis, with or without otitis media. There are many absences from school, and the child's school work is suffering. Re-evaluation during such an episode usually shows diffusely erythematous pharyngeal mucosa and hypertrophied tonsils. These children require more extensive evaluation. Blood counts, serum protein electrophoresis, sweat chloride test, and chest x-

---

Read before the Joint Session of the Sections on Allergy, Otolaryngology, and Pediatrics, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 7, 1972.

ray are performed in an effort to find an underlying etiology.

We do not place great faith in throat cultures, since even cases of severe acute exudative tonsillitis with temperature elevations to 104° which respond within 24 hours to penicillin, frequently fail to show pathogens on culture. The importance of allergy evaluation cannot be over-emphasized and will be discussed below. Once allergy, immune incompetence, and other etiologic factors are ruled out, the parents are carefully told that the tonsils *may* play a role in these illnesses, and surgery is recommended. No promise is made as to the therapeutic outcome, but patient and physician alike are so often pleased with the result that we feel this is a rational approach. We do not "push" the operation, and leave the final choice where it should lie—with the parents.

With the significant reduction in morbidity, it would seem logical to perform adenoidectomy only when the indications for tonsillectomy are absent.

### Adenoidectomy

Adenoidectomy is routinely performed in conjunction with tonsillectomy. Adenoid hypertrophy is often associated with enlargement of the tonsils. The adenoids are generally involved with the tonsils in acute and chronic inflammatory conditions of the throat. The morbidity from tonsillectomy is in no way increased by incidental adenoidectomy. The only contra-indications are velopharyngeal incompetence and a palpable submucous cleft. In these cases the lateral bands of tissue are removed to clear the torus tubarius and choanal regions, while leaving a central adenoid mass to insure adequate post-operative palatal closure during speech. The symptoms and afflictions resulting from adenoidal hypertrophy are well recognized. Adenoidal hypertrophy, causing nasopharyngeal blockage and inadequate ventilation of the eustachian tubes, suggests absolute indication for adenoidectomy. Other indications are lethargy, irritability, headaches, post-nasal drip, frequent colds, upper respiratory infec-

tions, epistaxis in children, impaired general health with faulty respiration, impaired vital capacity, and chronic bronchitis. Chronic pulmonary resistance, gastrointestinal conditions, nocturnal enuresis, and even convulsions can be symptoms of nasopharyngeal blockage. Cardiac enlargement, chronic ventricular hypertrophy, and cor pulmonale have also been associated with chronic upper respiratory obstruction.

Adenoidal blockage of the posterior nasal choanae, producing mouth-breathing, poor speech and breathing habits, as well as inadequate nasal ventilation with delayed paranasal sinus development, subsequent dental arch distortion and the development of "adenoid facies" would justify surgical eradication.

The most common and important indication for adenoidectomy is otitis media, serous or acute, chronic or recurrent.

Although acute mastoiditis has ceased to be a common complication of otitis media, there has been a twelve-fold increase in the incidence of chronic ear disease over the past two decades. Whether adenoid hypertrophy physically blocks the eustachian tube orifice, or whether chronic infection of the adenoids causes lymphoid hyperplasia or lymph stasis in the walls of the eustachian tube with secondary mucosal congestion, the results are tubal blockage, a relative vacuum formation in the middle ear with transudation of fluid and serous otitis media. Infection from nasopharyngeal lymphoid tissue may extend through the eustachian tube into the middle ear and result in frank suppurative otitis media and all its possible sequelae.

Unresolving middle ear effusion is the most common and most dangerous situation with persistent eustachian tube blockage causing the glue ear. Dense adhesions form in glue ears—with permanent scar tissue and permanent hearing loss. Surgical correction of these late stages are difficult and unrewarding. Adenoidectomy and myringotomy with trans-



tympanic ventilating tubes must be performed.

Permanent negative pressure in the middle ear from tubal blockage may cause cholesteatoma, eroding bone and soft tissue as it spreads to destroy the ossicles, the tympanic membrane, mastoid air cells, eventually the labyrinth and the dura of the temporal and occipital lobes.

These all-too-common sequelae of chronic or recurrent eustachian tube blockage may be prevented by the aggressive early treatment of the underlying pathology. If the doctor is involved with the otologic management of patients with cleft palate repairs, involving fracture of the malleus and secondary tensor veli palatine dysfunction, he will appreciate the seriousness and difficulty of management of the malfunctioning eustachian tube. The nasopharynx must be cleared of all irritating factors and the vacuum in the middle ear must be broken. The former is achieved with adenoidectomy, the latter with myringotomy and insertion of transtympanic ventilating tubes to maintain normal middle ear pressure.

The severity of these otologic and obstructive respiratory complications would clearly and specifically justify surgical eradication of the diseased tissue. The diagnosis of obstructive hypertrophic adenoid should present no difficulties and can be easily made by the use of a post-nasal mirror, nasopharyngoscopy, and direct inspection or palpation. Proetz displacement may be diagnostically employed to ascertain the actual degree of physical blockage in the nasopharynx. The differential diagnosis should include congenital atresia of the posterior nasal choanae, nasopharyngeal tumors and allergy.

## Allergy

The otolaryngologist, in his zealous approach for surgical cures, must not blind himself to the obvious signs and symptoms of allergy and these are quite familiar to all and the diagnosis of allergy should not be difficult. Considerable evidence has been accumulated demonstrating the immunologic role that tonsils and

adenoids play in the defense mechanism of the body.

Recent investigators have reported interesting findings regarding the presence of globulins in the nasopharyngeal lymphoid tissue, particularly in patients with respiratory allergies.

Should the otolaryngologist re-evaluate his indications for adenotonsillectomy in view of this new immunologic information in the field of allergy? The otolaryngologist has long shared in the development of allergy diagnosis and testing and is daily exposed to clinical allergic problems. Thus, he has always been acutely aware of the management of adenotonsillitis and otitis in allergic children, and has met the challenge with aggressive medical and surgical treatment.

There are three schools of thought regarding the relationship between tonsils and adenoids and allergy. On the one hand are those who believe that the tonsils and adenoids can act as a focus of infection and their removal can prevent or favorably influence asthma. Others believe that this tissue is important in the defense mechanism preventing the spread of infection and should not be removed under any circumstances.

It is our feeling that the indications for adeno-tonsillectomy are the same for the allergic and non-allergic individual and the indications for their removal, dependent solely on the presence of infection and not on the effect the removal will have on the allergic process.

Physicians who maintain that tonsils and adenoids should never be removed are concerned with the immunologic role of this tissue on the growing child. However, there has been no indication—or even suggestion—over the past seventy years that there is any immune incompetence of those millions of children who underwent surgery.

The lymphoid tissue of Waldeyer's Ring is capable of producing antibodies and discharging immunoglobulins on the mucosal surfaces. Such antibodies as anti-influenza and

anti-polio globulins have been isolated from lymphoid tissue in the pharynges. However, the protective role of tonsil and adenoid tissue exists only as long as these tissues are not diseased. Whatever its function might be under normal conditions, when chronically infected or significantly hypertrophied, this function is likely lost or altered to the extent that it no longer exerts any beneficial action, but tends to serve as a nidus for discharge of infected material and to encourage infectious afflictions. The "truism" that tonsillectomies cure only the tonsillitis is misleading, especially in allergic individuals, and any of the conditions commonly attributable to foci of infection, asthma included, may be due to chronic adeno-tonsillitis. However, care should be taken not to condemn the tonsils as the cause just because they are visible and accessible.

Even though immunoglobulins have been isolated in tonsils and adenoid tissue, the importance of this particular lymphoid tissue in the over-all body system of immune response is

still under question since there is no clinical change in resistance to infectious disease following surgery.

### Summary

Adeno-tonsillectomy in the allergic individual necessitates careful thought and consideration of the surgical indications as well as the underlying allergic problems.

Indications for adeno-tonsillectomy and adenoidectomy, with or without transtympanic ventilating tubes, have been presented. Surgery is performed only when specifically indicated.

Evaluation and control of allergy problems are important and prior to surgery, allergic management, if possible, is mandatory. The allergic problems may be more easily controlled, if and when foci of infection, such as chronically diseased lymphoid tissue, are eradicated.

258 Broad Street

## A Military Medical School

Establishment of a military medical school is authorized under a recently enacted law. A companion program will provide up to 5,000 full federal scholarships in effect at one time for students to go to civilian medical schools if they agree to serve in the armed services for five to seven years after graduation. The scholarships would provide the full cost of tuition and fees and \$100 a week living allotment.

The military medical school is to be called the Uniformed Services University of the Health Sciences and is to be located within 25 miles of Washington, D.C. It will be set up to have 100 graduates a year. Authorization of the military medical school capped with success a long fight of Rep. F. Edward Hebert (D., La.), chairman of the House Armed Ser-

vices Committee.

Related legislation, which was supported by the American Medical Association, would raise the pay of military physicians to attract them to the armed services. Ernest B. Howard, M.D., Executive Vice President of the AMA, wrote the House Armed Services Committee: "The American Medical Association supports the principle of special incentives through which the Armed Forces may secure and retain qualified medical officers on active duty. This approach is entirely consistent with the concept of an all-volunteer Armed Force, which would require adequate manpower in the critical health professions. We support incentives designed to provide adequate medical manpower on a more equitable financial basis."



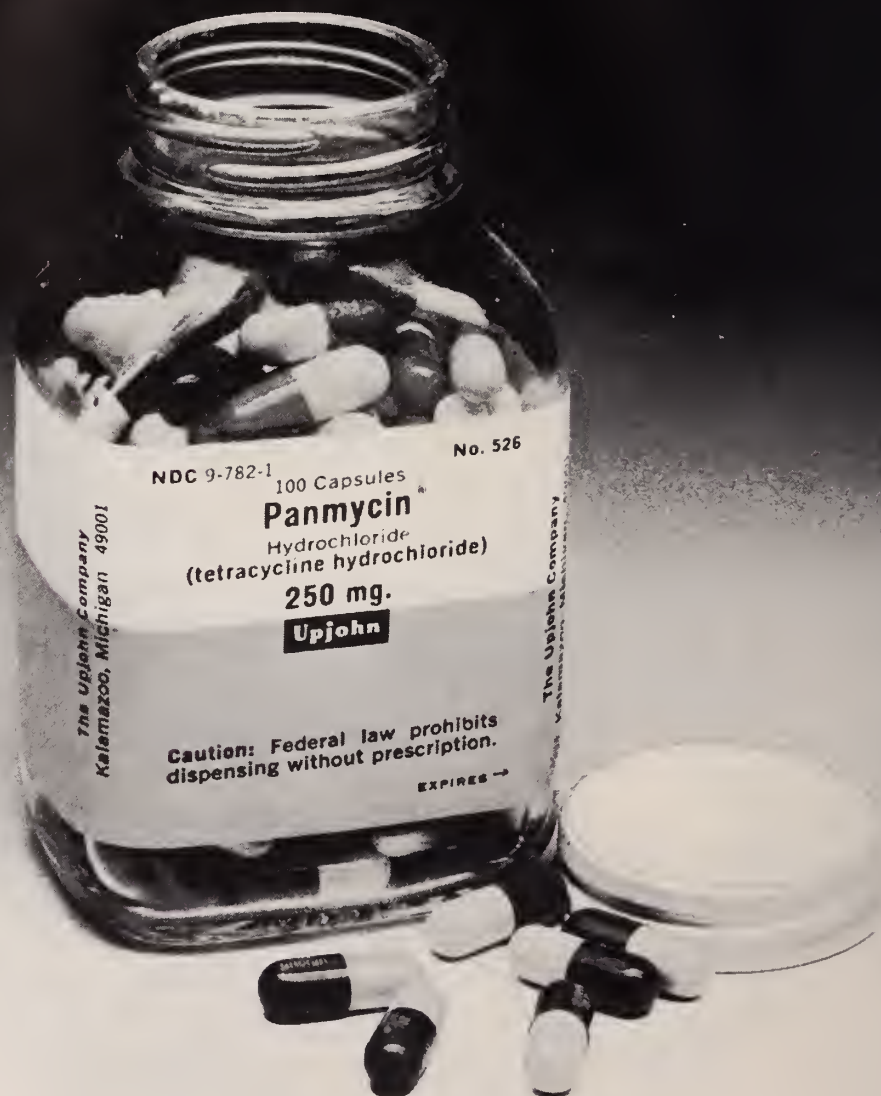
0.5 Gm tablets  
**ORINASE<sup>®</sup>**  
tolbutamide, Upjohn

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan 49001  
JA72-2407-6  
© 1972 The Upjohn Company



# Upjohn's low-priced tetracycline



## Panmycin<sup>®</sup>

(tetracycline HCl, Upjohn)  
Available as 250 mg capsules and  
tetracycline syrup 125 mg/5 ml

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2142-6

*Acute gastrointestinal ulcerations and erosions are often life threatening to critically ill, hospitalized patients.*

# Acute Gastrointestinal Erosions and Ulcerations in Critically Ill Patients\*

**Victor W. Groisser, M.D., et al./Montclair**

One of the most challenging gastrointestinal problems today is that of massive upper gastrointestinal hemorrhage.

Severely ill patients admitted to the hospital for a variety of causes may bleed from the upper gastrointestinal tract<sup>1</sup> during their hospital stay as a consequence of underlying stress.<sup>2</sup> The stressful situations include causes such as overwhelming sepsis, major surgery, severe prolonged illnesses, trauma, shock, respiratory insufficiency, and burns. In the already debilitated and critically ill patients these bleeding episodes are often fatal. The underlying lesion is generally found to be hemorrhagic erosive gastritis and acute gastric and duodenal ulceration, the so-called "stress ulcer."

In addition, mortality statistics in patients admitted to the hospital after massive gastrointestinal hemorrhage may be as high as 15 to 20 per cent.<sup>3</sup> Of this group 20 to 30 per cent of the patients will be found to be bleeding from erosive gastritis and/or acute ulcerations of the upper gastrointestinal tract. Alcohol and salicylates are the prime offenders in this group.

In view of the frequent occurrence of these superficial erosions and ulcerations we should like to explore the problem further in both groups of patients: those patients who are admitted with massive gastrointestinal bleed-

ing secondary to acute mucosal lesions induced by exogenous agents and those stressed patients who develop these acute mucosal lesions while in the hospital.

In 1961 we studied a group of 32 patients admitted to the Jersey City Medical Center—Seton Hall College of Medicine—with massive gastrointestinal hemorrhage secondary to erosive gastritis and acute gastric ulcers. (Table 1). In all of these the diagnosis of gastric erosions and acute ulcerations was definitively established by gastroscopy (28 of 32 patients). In four it was established only at time of surgery. The lesions were typical of acute mucosal lesions involving loss of epithelium and some lamina propria in the case of erosions with extension to the muscularis mucosa in the instance of acute ulcers. In 22 of the patients hematemesis was the primary symptom with melena present in the remainder.

Many of these patients were critically ill requiring emergency procedures and therapy. Age range was between 17 and 74 years with an average of 43 years. In 18 patients alcohol was ingested; in 12, salicylates were the cause of gastrointestinal bleeding; in one, colchicine was the offending agent. In one patient

\* Read before the Sections on Gastroenterology and Proctology and General Practice, 206th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 8, 1972. Dr. Groisser is Clinical Professor of Medicine, College of Medicine and Dentistry of New Jersey. Coauthors are John DiBianco, M.D., Assistant Professor of Medicine, and Florenzio Yuzon, M.D., Clinical Assistant Professor of Medicine, CMDNJ.

TABLE I

*Erosive Gastritis and Acute Gastric Ulceration as  
a Cause of Massive Gastrointestinal Hemorrhage*  
(32 Patients Studied at the Jersey City Medical Center—1961)

Presenting symptom	Hematemesis and melena—(22 patients)
Age	17-74 years; Average 43 years
Sex incidence	Males—24; Females—8
Etiology	Alcohol—18; Salicylates—12; Colchicine—1; Undetermined—1
Initial impressions	Peptic Ulcer—21; Varices—1; Erosive Gastritis—10
Pathology	Diffuse and Discrete Erosions and Acute Ulcerations
Diagnosis made by	Gastrosocopy—28; Surgery—4
Treatment	Gastric Cooling by Saline Lavage; Antacids; Surgery (5 patients)
Units of blood transfused	Total—96; Range 1-19; Average—3
Prognosis	4 Deaths, 3 Following Surgery, 28 Patients Recovered Completely

we could not determine the nature of the medication ingested prior to admission.

Twelve of the 32 patients were thought to have a peptic ulcer prior to diagnostic work-up. One patient was surmised to have varices and ten were diagnosed correctly on admission as having hemorrhagic erosive gastritis.

Work-up was performed actively. All diagnostic studies were completed within 72 hours. In all patients, the gastrointestinal x-rays were negative. Twenty-eight were gastroscopied within 48 hours of admission. Gastrosocopy was the single most helpful modality in making a definitive diagnosis. In four patients who were *not* gastroscopied (because they were bleeding too massively) the diagnosis was established at surgery. (Table 1). In addition to these modalities a fluorescein string test was employed as an ancillary diagnostic help in twelve patients. The test was used in conjunction with a Diagnostotube—a specially prepared tube with an absorbent sheath over a flexible plastic core containing a numbered wire to help identify the site of hemorrhage.<sup>4</sup>

With the diagnosis established, therapy consisted primarily of sedation, gastric cooling by ice saline lavage, antacids, and a bland diet. On this regimen most patients responded to therapy. Five patients required surgery because of the persistence of the bleeding.

A total of 96 units of blood was utilized with a range of 1 to 19, and an average of 3 units

per patient. The bleeding episodes in many instances were quite massive. In this group of 32 patients, four patients died, three following surgery. This is not a comment on the effectiveness of surgery but rather the fact that only the most severely ill patients were finally referred for surgical therapy. Surgery included vagotomy and pyloroplasty and sub-total gastrectomy.

When the alcohol versus the aspirin bleeders were compared the following was noted. Both groups of patients bled with equal severity in our series. In all patients who ingested alcohol the erosions tended to be more diffuse. The mucosa was edematous and erythematous as well. In the patients who ingested salicylates the erosions were localized, being found primarily in the antrum and on the greater curvature of the stomach.

Hemorrhagic erosive gastritis and acute gastric (as well as duodenal) ulceration are a significant cause of massive gastrointestinal hemorrhage.<sup>1, 2, 5</sup> A growing list of exogenous agents will produce these lesions. More alcoholics who are currently drinking will bleed from acute mucosal lesions than from esophageal varices.<sup>5</sup> Salicylate bleeding may occur from taking a large number of aspirin or from an idiosyncratic reaction, even after the ingestion of 5 to 10 grains of aspirin.

Hematemesis occurred twice as frequently as melena as the presenting complaint. This has been noted previously.<sup>5</sup>



Gastrointestinal x-rays will not reveal gastric erosions and superficial ulcerations. Many physicians erroneously ascribe the bleeding to a chronic peptic ulcer which has escaped x-ray detection. For proper diagnosis and appropriate therapy it is imperative that upper GI endoscopy be performed. Today with the availability of fiber-optic esophagoscopes, gastroscopes, and duodenoscopes, with the patient well sedated with intravenous Demerol® or Valium®, these procedures can be performed effortlessly, with the patient lying comfortably in his bed or on an appropriate examining table.

*What is the most efficacious way to manage patients bleeding from acute mucosal erosions and ulcerations?*

First, the offending agent should be eliminated. In a patient with a salicylate-induced hemorrhage, do not give aspirins to reduce an elevated temperature. Rectal administration will not obviate the danger of this drug.

Over-all management should be guided by the knowledge that most bleeding episodes secondary to acute mucosal lesions can be controlled by medical measures. The patient should be sedated. Adequate blood replacement is a necessity. Coagulation factors should be checked and corrected where abnormal. Ischemia and shock should be treated energetically. If a patient has stopped bleeding antacids and milk should be initially instituted.

For the patient who continues to bleed we advocate that an 18 French Levine tube be passed and the stomach lavaged with ice saline or ice water. This should be continued as long as is needed, hopefully for 20 to 30 minutes each hour in divided periods, depending on the availability of skilled house staff or nursing assistants. If practical, constant lavage would be most efficacious.

Should the patient continue to bleed profusely, gastric hypothermia should be instituted. We have had good success with this.<sup>6</sup> This procedure is not to be confused with gastric

freezing now in disrepute for the treatment of chronic peptic ulcers. Using the gastric hypothermia method fluid is circulated in a closed bag system—the bag within the stomach—through a refrigeration unit at the bedside which delivers a constant flow of a cooling solution to the stomach at a pre-set temperature, often at 2 degrees Centigrade. Vasoconstriction in the area of the stomach is significant, and both pepsin and hydrochloric acid are reduced to 50 to 75 per cent of pre-cooling values. With this therapy carried on for 36 to 48 hours many otherwise uncontrollable bleeders will respond to therapy. Should the diagnosis be in error and varices or a chronic ulcer be present there is also some response in the reduction of blood flow and/or cessation of bleeding in these instances in a significant number of patients.

Some clinicians have used propanthine in high doses to produce a so-called "medical vagotomy." This method has not been adopted by most physicians. Of no real value are topical thrombin, intravenous premarin, and systemic hypothermia.

Pitressin delivered directly into the celiac plexus *via* an indwelling catheter threaded into the aorta and the administration of growth hormone to stimulate regrowth of denuded gastric mucosa are methods presently under investigation.

If all else fails, surgery should be done before the patient becomes ischemic and/or develops irreversible shock. Vagotomy and pyloroplasty have been in vogue for many years but there has again been a renewed interest in vagotomy plus antrectomy or vagotomy plus sub-total gastrectomy. In some instances total gastrectomy will be necessary but hopefully these occasions will be uncommon.

### **Acute Gastric Erosions and Acute Gastric (and Duodenal) Ulcerations in Severely Ill and Dying Patients**

In the emergency service of one large hospital more patients required transfusion as a consequence of stress ulceration secondary to sepsis

and trauma than required blood for peptic ulcer and variceal hemorrhage.<sup>7</sup>

With advances in medicine and with the advent and growing use of our intensive care, coronary care, and respiratory care units, we are noting<sup>1, 2, 7</sup> an increasing incidence of massive gastrointestinal hemorrhage in critically ill patients whose lives can now be sustained. Many of these patients are vulnerable to the development of stress induced ulceration and hemorrhage.

**TABLE II**

*Hospital Patients Who Are Most Prone to Stress Ulceration and Gastrointestinal Hemorrhage*

1. Patients with severe debilitating illness, patients who have had major surgery, patients who have experienced severe trauma, and patients with overwhelming sepsis from any cause.
2. Patients with brain tumor, head trauma, cerebrovascular accidents and patients who have neurosurgical procedures involving the brain ("Cushing's ulcers").
3. Patients with severe respiratory insufficiency, patients in shock, patients with severe myocardial infarction.
4. Patients with severe burns ("Curling's ulcers").

Table II lists broad groups of patients who are prone to the development of stress induced mucosal lesions.

The pathologic nature of the acute erosions and ulcerations, the method of diagnosis and the therapeutic approach as regarding massive gastrointestinal hemorrhage in these patients are essentially the same as in the previous discussion. The precise pathogenetic mechanism of the stress-induced acute mucosal lesion is unknown. Theories regarding etiology include: micro-infarcts and micro-emboli in the gastric circulation, ischemic infarcts secondary to anoxia from vasoconstriction or passive congestion, abnormal mucus production, increased acid production, and diminished integrity of the mucosal lining. The initiating factors may involve the effect of stress as mediated through vagal and sympathetic stimulation and ACTH release (Table II).

Consider the severely debilitated patient and the patient with overwhelming sepsis. Nowhere is the threat to life as great as in

these patients who already are in danger of dying from some severe medical disease who then develop massive gastrointestinal hemorrhage from stress ulceration. In some of these patients sudden death may ensue as a result of massive hemorrhage which may not be noted<sup>8</sup> until autopsy.

The patient who does manifest hematemesis and/or melena should be treated according to the previous recommendations. Early blood replacement is necessary to prevent ischemia and irreversible shock. It is a mistake to rely on vasoconstrictors in these cases where ischemia and hypovolemia are the real issues. Continued attention to the basic underlying medical problem is essential.

Patients with brain tumor, head trauma, cerebrovascular accidents, and those who have neurosurgical procedures involving the brain ("Cushing's ulcers"). "Cushing's ulcer" is an acute ulceration of the stomach and/or duodenal bulb. Bleeding may often be controlled in these patients even though some of the patients are in coma. We recently saw a 17-year old patient with multiple fractures and mid-brain damage as the consequence of a motorcycle accident. The patient was in coma for two months. During his fourth hospital week while in the Intensive Care Unit he developed massive gastrointestinal hemorrhage. Fiber gastroscopy could be performed in this semi-comatose individual at his bedside. Numerous discrete acute ulcerations were noted. The bleeding was massive but responded to ice saline lavage. Three weeks later a similar type of gastric bleeding ensued. Again ice saline lavage treatment was efficacious. This patient is now out of the hospital, out of coma, and is recuperating. The lesson to be learned is that coma does not interdict the use of appropriate measures to control acute mucosal bleeding lesions.

Patients with severe respiratory insufficiency, patients in shock, patients with severe myocardial infarction have been noted<sup>8</sup> to develop stress ulcers. In a group of 200 unrelated patients who died from gastrointestinal hemorrhage seven exsanguinated from stress

ulcers secondary to myocardial infarction. Acute gastric ulcers and gastrointestinal bleeding developed in eight of the first 150 patients seen in a respiratory surgical care unit.<sup>9</sup>

Eleven per cent of patients with severe burns have been found to develop mucosal ulcerations ("Curling's ulcers") in the upper gastrointestinal tract.<sup>10</sup> When bleeding ensues, mortality rate is usually high.

It would be wise to treat all burn patients prophylactically with antacids and a bland diet.

In summary, hemorrhagic erosive gastritis and acute mucosal lesions are often the cause of massive gastrointestinal hemorrhage either from exogenous causes or from stress producing events. There are a growing number of patients who are seen with acute mucosal lesions and bleeding who come to the hospital because of the bleeding following the use of exogenous agents.

Perhaps an even larger number of patients

develop GI hemorrhage while in the hospital for severe debilitating illness. These "dying" patients and these critically ill patients (particularly those in our intensive care units) are prone to develop stress ulcerations. If recognized early appropriate therapy may be instituted. Because of the nature of the severe underlying illnesses, the mortality rate is high. However, many patients may be saved by knowledge of the entity and early application of the measures discussed.

## Bibliography

1. Markowitz, A.: *Med. C.N.A.*, 55: 1277 (1971)
2. Grosz, C. and Wu, K.: *Surgery*, 61: 853 (1967)
3. Enquist, L., *et al.*: *Ann. Surg.*, 163: 550 (1965)
4. Nissenbaum, G., *et al.*: *Gastroenterology*, 49: 662 (1965)
5. Katz, D. and Siegel, H.: In *Progress in Gastroenterology* by George B. Glass, New York, Grune and Stratton, 1968.
6. Groisser, V. W.: Unpublished observations
7. Lucas, C., *et al.*: *Arch. Surg.*, 8: 102 (1971)
8. Berkowitz, D.: *Am. J. Gastro.*, 8: 372 (1963)
9. Skillman, J. and Bushnell, L.: *Am. J. Surg.*, 117: 523 (1969)
10. Hummel, R., Landschamlin, G., and Artz, G.: *JAMA*, 64: 141 (1957)

21 Plymouth Street

## Nitroglycerin Packaging Affects Potency\*

A recent FDA assay survey of nitroglycerin tablets suggests that improper packaging has a bearing on the drug's stability and potency. The assay involved nitroglycerin tablets stored in a pen-shaped plastic container provided by pharmacies as a convenient means of carrying several days' supply. Dispensers containing the drugs were left standing at room temperature for one, two, and three-day periods.

The nitroglycerin was found to have decreased to about 50 per cent, 30 per cent, and 20 per cent of initial potency after being left in the dispensers for these periods. FDA has

requested recall of the dispensers. The assay led FDA to conclude that unexplained patterns of therapeutic response by patients to nitroglycerin therapy may be caused by the manner in which the drug is packaged. Physicians should consider this possibility when evaluating patient response to the drug.

To avoid rapid loss of potency, nitroglycerin should be kept, at all times, in tightly-sealed glass vials. Physicians and pharmacists may wish to tell patients this when prescribing and dispensing the drug.

\* From the February 1972 FDA Bulletin



# THE MEDICAL SOCIETY OF NEW JERSEY

## Professional Liability Insurance Program

### Society Endorsed Coverages—

- Professional Liability for  
Individuals  
Partnerships and Professional Corporations  
Employed Nurses, Technicians or Aides
- Professional Premises
- Excess (Umbrella) Liability—Limits up to \$5 Million

### Management of Loss Control Program—

- Claims Peer Review
- Prompt Advice Regarding Potential or Actual Claims
- Defense by Highly Skilled and Experienced Counsel
- Investigation by Specialists in Malpractice

## JOSEPH A. BRITTON AGENCY

15 South Munn Ave., East Orange, N.J. 07018

(201) • 673-3060

The treatment of

# impotence

due to androgenic deficiency in the American male.  
The concept of chemotherapy plus the  
physician's psychological support is confirmed  
as effective therapy.

NEW  
CLINICAL  
STUDY

The Treatment of Impotence  
with Methyltestosterone Thyroid  
(100 patients—Double Blind Study)  
T. Jakobovits  
Fertility and Sterility, January 1970  
Official Journal of the  
American Fertility Society

**Android**<sup>®</sup>  
(thyroid-androgen) tablets



### Double-Blind Study and Type of Patient:

100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

### Choice of 4 strengths:

#### Android

Each yellow tablet contains:  
Methyl Testosterone .25 mg.  
Thyroid Est. (1/6 gr.) .10 mg.  
Glutamic Acid .....50 mg.  
Thiamine HCL .....10 mg.  
Dose: 1 tablet 3 times daily.  
Available:  
Bottles of 100, 500, 1000.

#### Android-HP

HIGH POTENCY

Each red tablet contains:  
Methyl Testosterone .50 mg.  
Thyroid Est. (1/3 gr.) .20 mg.  
Glutamic Acid .....50 mg.  
Thiamine HCL .....10 mg.  
Dose: 1 tablet 3 times daily.  
Available:  
Bottles of 100, 500, 1000.

#### Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:  
Methyl Testosterone .125 mg.  
Thyroid Est. (1 gr.) .64 mg.  
Glutamic Acid .....50 mg.  
Thiamine HCL .....10 mg.  
Dose: 1 or 2 tablets daily.  
Available:  
Bottles of 60, 500.

#### Android-Plus

WITH HIGH POTENCY  
B-COMPLEX AND VITAMIN C

Each white tablet contains:  
Methyl Testosterone .25 mg.  
Thyroid Est. (1/6 gr.) .15 mg.  
Ascorbic Acid (Vit. C) .250 mg.  
Thiamine HCL .....25 mg.  
Glutamic Acid .....100 mg.  
Pyridoxine HCL .....5 mg.  
Niacinamide .....75 mg.  
Calcium Pantothenate .10 mg.  
Vitamin B-12 .....2.5 mcg.  
Riboflavin .....5 mg.  
Dose: 2 tablets daily.  
Available: Bottles of 60, 500.



**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

**Hypercalcemia** may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montezano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. *Clin Med* 12:69, 1966. 2. Dubus, M. F. Treatment of impotence with methyltestosterone-thyroid compound. *West Med* 5:67, 1964. 3. Telford, A. S. Methyltestosterone-thyroid in treating impotence. *Gen Prac* 25:6, 1962. 4. Hellman, L., Bradshaw, N. L., Zamarr, B., Fukushima, G. K., and Gallagher, T. F. Thyroid-androgen interrelationship and the hypochlosteremic effect of androsterone. *J Clin Endoc* 19:336, 1959. 5. Farris, E. J., and Cattan, S. W. Effects of L-thyroxine and dihydroxycholesterol on spermatogenesis. *J Urol* 79:863, 1958. 6. Osai, A., and Farrar, G. E. United States Dispensary (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershow, L. F. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057

*In these days of burgeoning non-prescription use of medications, the warning given here is appropriate.*

# Toxic Thrombocytopenic Purpura Following Use of a Nonprescription Medication\*

**Norman N. Kohn, M.D./Cinnaminson**

Many nonprescription drugs, promoted as "sleep-aids," are available to the public. Some of the widely advertised preparations (such as *Nytol*, *Sleep-Eze*, and *Sominex*) contain the antihistamine methapyrilene in combination with either a salicylamide or scopolamine. The accompanying descriptive material may contain expressions such as "safe" and "hospital-tested" to assure the consumer of their innocuousness. The following case report raises questions about the accuracy of those claims.

A 66-year-old woman, recently widowed, had been in good health until three days prior to hospital admission for "black-and-blue" marks of the arms and legs. No other spontaneous bleeding had been noted. For a three week period before noting these marks, she had taken one or two *Nytol* tablets at bedtime every other night in an attempt to promote sleep. These had been purchased in a local supermarket and each contained 25 milligrams of methapyrilene and salicylamide (amount per tablet unspecified on wrapper). No other drugs had been used. On hospital admission the physical examination was normal except for large purpuric areas on the skin of all extremities and the trunk. The following studies were normal: red and white cell count, differential cell count, blood urea nitrogen, fasting blood sugar, electrolytes, several lupus preparations, plasma protein electrophoresis, serum albumin and globulin, bromsulphalein test, chest x-ray, and electrocardiogram. The initial platelet count was 5000/mm<sup>3</sup>. Urinalysis contained 24-26 red cells/h.p.f. but was otherwise normal. The bleeding time was 5 minutes and 45 seconds (normal is 1 to 3 minutes). Sternal bone marrow aspirate showed no abnormality of red or white cell formation; megakaryocytes were strikingly diminished with little platelet formation. The observed changes were felt to be compatible with drug-induced thrombocytopenia.

A diagnosis of thrombocytopenic purpura due to methapyrilene and salicylamide was made. Therapy was instituted promptly with prednisone 80 milligrams per day. The platelet count rose to 86,000/mm<sup>3</sup> in five days. Subsequent urinalyses contained no red cells.

Purpura resorbed and no new areas appeared. Corticosteroid therapy was continued in tapering dosage over a two month period with the platelet count stabilizing at 250,000/mm<sup>3</sup> after stopping therapy. No recurrence of thrombocytopenia has taken place during a three month period of subsequent observation.

## Comment

This patient developed severe thrombocytopenic purpura soon after beginning use of an antihistamine-salicylamide combination in the form of *Nytol*. The evidence directly attributing the thrombocytopenic syndrome to the previously ingested drugs is admittedly circumstantial. However, this sequence is not unique. Severe blood disorders due to bone marrow depression have previously been reported both from salicylates and from antihistamines. These have included agranulocytosis<sup>1</sup>, fatal pancytopenia<sup>2</sup> and fatal toxic thrombocytopenia<sup>3</sup>. In addition, standard references on drugs and drug reactions cite thrombocytopenia as a possible reaction both to salicylate and to antihistamine administration.<sup>4, 5, 6</sup> Aside from hematologic disorders, the abuse of this class drugs for suicidal purpose is well known and a recent communication<sup>7</sup> describes fatal poisoning from methapyrilene in the form of *Sominex*.

In view of the increased availability of non-prescription drugs and the widespread use and misuse of them by individuals in quest of a panacea for their symptoms in the form of a "pill," physicians must increase their

\*From the Division of Medicine, Rancocas Valley Hospital, Willingboro, New Jersey.

surveillance for the type of drug-induced illness described here.

### Summary

A 66-year old woman developed dangerous thrombocytopenia following the use of *Nytol*. Following corticosteroid therapy, complete recovery ensued. This sequence is not unique and may be seen more often in the future with the increased use of nonprescription "sleep-aids."

*Acknowledgment:* The author wishes to thank Edwin Messey, M.D. for his kind permission to study this patient while she was hospitalized.

Cinnaminson Medical Center

### Bibliography

1. Cahan, A., Meilman, E., and Jacobson, B. M.: *N. Eng. J. Med.*, 241:865 (1949)
2. Glassmire, C. R.: *J. Maine Med. Assn.*, 51:85, (March 1951)
3. Rappaport, A. E., Nixon, C. E., and Barker, W. A.: *Lab. Clin. Med.*, 30:916 (1945)
4. *AMA Drug Evaluations*, First Edition. Chicago. American Medical Association, 1971. P. 368.
5. *The Medical Letter on Drugs and Therapeutics* 13:103 (1971)
6. *Cecil-Loeb Textbook of Medicine*, 13th Edition. Philadelphia, Saunders, 1971. P. 1601.
7. Fatteh, A.: *JAMA* 219:756 (1972)

### Medicare Institutional Reimbursement

Proposed regulations revising the methods by which hospitals and extended care facilities are reimbursed their costs in providing services to Medicare beneficiaries have been announced by Robert M. Ball, Commissioner of Social Security. These changes will simplify cost finding and cost reporting requirements for smaller institutions. The revisions are an outgrowth of various recommendations made by the Senate Finance Committee.

Under current Medicare regulations two methods are used for determining what proportion of an institution's allowable costs are attributable to Medicare beneficiaries. One is "Departmental Method" under which the ratio of Medicare patient charges to total patient charges is applied to the costs of each department of the hospital or extended care facility to come up with the Medicare share of total costs.

The other is the "Combination Method" under which the cost of routine services for Medicare beneficiaries is determined on an average cost *per diem* basis and the cost of ancillary services is determined based on the Medicare portion of the aggregate charges applied to cost.

### Imipramine and Birth Defects

Recent alarm about possible implication of imipramine (Tofranil®), an anti-depressant drug, in birth defects (amelia and phocomelia) appears to be without firm foundation. A report of an association between imipramine given pregnant mothers and deformities in offspring came from Australia in March, 1972.

The Australian Department of Health recently informed the FDA that it regards as inconclusive the data on which the report was based. The Department of Health in London told FDA that in eight years the Committee on Safety of Drugs received one report of abnormality associated with imipramine.

FDA-approved imipramine labeling in use since 1965 contains the following warning: "Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant women, nursing mothers, or women of child-bearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed."



# Career Commitments in Medicine\*

---

**Stanley S. Bergen, Jr., M.D./Newark**

As a group, you have undergone a special experience during the last two years. As a group of 16, you have grown in a unique manner. You are to be the last class of 16 to graduate. Hopefully, you will take with you some flavor of this experience and it will affect your approach to learning and service in the field of medicine as you apply the art of healing to the ill.

From all sides, we are receiving a message, "We are in the middle of a health crisis." What is meant by this statement? As they speak, are health care spokesmen, state and federal legislators, and the public trying to tell us something? Is there a message that we should hear?

There is no doubt that we are in an era of change. Significant changes in the social attitudes of our country are taking place and have taken place over the last ten years. Is it merely the fact that this social change is now manifesting itself in the health care field that is being interpreted as a crisis? Is the health care industry being asked to respond as it has never had to respond before? Or, in fact, are we seeing a reaction. Are we merely experiencing a greater citizen involvement—an involvement that started with the youth, the poor, and the minority groups, an involvement that is now spreading to all levels of income, to all levels of consumer and public participation?

We could interpret the message as a dissatisfaction with our accomplishments. I don't be-

lieve this would be an accurate interpretation. Rather, I think it is incumbent upon the medical profession as leaders in the health care field to be aware of the fact that we may not have produced in a manner that satisfies public expectation. When one considers the tremendous resources that have been committed to health care in the last 20 years, considers that as an industry we rank second only to defense in spending, and considers that 63 billion dollars will be spent this year for health, is the public properly served? The medical advances that have been brought about by the commitment of funds, facilities, and manpower are staggering. However, at the same time, the application of these advances, the benefit felt by the individual citizen and by the patient, have not matched the accomplishments.

Today, we are being asked to examine the need for a serious and widespread change in our institutional system—a system-wide change that will lead to improved delivery of health care to all economic levels of our population and to all groups, young or old, rich or poor. We must hear this message. You will be forced to listen, hear, and react. It is a message of need. It is a request to those of us who can satisfy this need to be responsive, to understand. No longer are only the poor beset by the difficulty of obtaining health care services. Today, many of our citizens find it difficult to gain entry into a coordinated comprehensive health care system.

As you move forward in your educational ex-

---

\*Delivered May 28, 1971 at the graduation ceremonies of the Rutgers Medical College, CMNJ.

perience, as you are faced with the necessity of making a choice as to career commitments, you will realize that demands are increasing for you to commit yourselves to a medical career that is responsive to the social needs of our people. We will look to you as the next generation of health care providers to continue the development of a system that will provide readily available access to health care professionals and provide the educational opportunities whereby the public can become informed concerning its role in health maintenance.

Now this message as I receive it does not mean that our people expect all doctors to become general practitioners. Nor does it mean that we have overspecialized or performed more research than was feasible and applicable. Rather, I believe the message is a request, a request to develop a system that will allow the application of the great benefits that can be reaped from specialization, research, and education.

The medical school must always provide the repository of knowledge. It must provide the environment for study, the laboratories for research, and the workshop for the advancement of the state of the art. The people have given that responsibility to the medical school and its leaders. Some of you will seek out careers in research and education. You will become a part of that reservoir of knowledge, a reservoir which we must maintain, improve and transmit to subsequent generations of students and physicians. However, at the same time, we are being asked to share that reservoir more widely than we have in the past. We are being asked to develop an organizational system that will provide health care to those who now find themselves lacking adequate medical services, to use the same talents that have been used to attain great advancement in the basic sciences in order to provide for the successful clinical application of discovery. The public wishes us to organize our resources better.

One of the major defects in the health delivery system in the past has been the complete

dependence upon the physician as the sole provider of care. In the future, we will find a greater distribution of health care responsibilities to other health professionals and allied health groups. We are already seeing this take place in the intensive care unit nurse, the physician's assistant, and other members of the team who are being trained to deliver specific component parts of health care to the patient.

You will experience great changes in this area as you proceed in your education. You must be alert to the need to consider all possibilities that can broaden our delivery potential. You must be ready to accept the team approach to health care and utilize this approach to provide preventive care as one of the major challenges of the future.

As paradoxical as it might seem, we must be careful that as we become involved in the organization of delivery, we do not develop a sterile and impersonal system. As we attempt to improve the health care delivery system and develop new ways of delivering health care, we must not forget the consumer, our patient. We must satisfy his needs and must provide the health care he seeks in an acceptable manner. Remember, as you mature to physicians, the focal point of medical care is the patient. The sensitive care of each patient is the reward of our profession. We must be respectful of the patient's faith and trust in the physician. We must not violate this trust. Use your patient's eyes as a reflection of your ability to solve his problems. Truth emanates from the interaction between doctor and patient. A sacred contract will be formed with each patient who comes into contact with you. Yes, there will be things that he will do and say that anger you. There will be times when he will not follow your instructions, he will frustrate you. But remember, he is the patient. He is dependent upon you. You must be sensitive to his needs.

As you go forward from this medical school, seek out knowledge, your patients will depend upon you to know the answers. You must continue to learn throughout your career.

You must keep abreast of changes in medical care and you must be aware of how these changes can be applied to the health of your patients. The patient is at your mercy, he has no accurate standards by which to measure your knowledge or your ability. He must trust that you are conscientious and that you keep his needs foremost in your thoughts.

Your faculty has worked with you for two years and now sends you forward to further

learning. During the next two years of clinical experience, you will have contact with many patients. Some will offend you, some will warm your hearts, some will lead to deep sadness and sorrow. Scars will develop that you will never be able to remove from your personality. Never forget the trust that these patients will place in your hands, never forget the respect that they must develop for you and never forget the respect you must have for them. Do not let them down.

100 Bergen Street

### The Search for Narcotic Antagonists

An intensified pursuit of non-addicting chemical compounds for treating heroin addiction has been announced by the White House Special Action Office for Drug Abuse Prevention and the National Institute of Mental Health. Nine research contracts totaling more than \$2 million for clinical and preclinical testing of "narcotic antagonists" are funded by NIMH, an agency of HEW's Health Services and Mental Health Administration.

"This represents a major drive to develop new therapeutic agents which will assist patients to rid themselves of addiction and avoid returning to previous drug habits once they have been rehabilitated," explained Dr. Jerome H. Jaffe, Director of the Special Action Office. Seven of the new contracts are for studies of antagonists such as "cyclazocine" on which there already exists a substantial body of animal research data indicating potential value for treating heroin addiction. Two contracts are for preclinical studies in animals of the pharmacology and toxicology of several new narcotic antagonist compounds. In all, the research contracts total \$2,012,900.

Antagonists have little or no abuse potential and may provide a useful modality that can assist the addict in becoming drug free. Antagonists may be especially useful in treating groups of patients for whom methadone therapy is not advised, such as youths under

18 or individuals who have been using heroin only for a brief time. One major advantage of antagonists may be in preventing "experimenters" from becoming addicts. American medicine now has the knowledge to detect heroin use by means of reliable and rapid tests.

Some medical or community groups might elect to use such technics in high risk populations in the way that chest x-rays were used in populations with a high risk of tuberculosis, and thereby discover heroin experimenters before they become addicted, involved in crime, and die of overdoses. Once diagnosed, these early potential addicts could be "temporarily immunized" by daily treatments with antagonists. Previous research has indicated that narcotic antagonists have potential for controlling two factors which are pivotal in many addicts' inability to break them of heroin habits. First, an antagonist could block the heroin induced "high" or euphoria, a brief but extremely pleasureable effect in the user which acts as a strong reinforcer to continued drug taking. Second, the antagonist could help him avoid returning to heroin during the initial months of abstinence, and assist in making the addict more amenable to other forms of therapy needed to rebuild his life. Eventually, it is hypothesized, the tendency to return to drug using behavior would be reduced, both through the absence of reinforcement and the competing presence of other supportive help.





**Ampicillin, Carbenicillin, Oxacillin...**

# IMAGINE YOUR PRACTICE WITHOUT THEM

In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

Need we say more?

Prescribe the discoverer's brands:

**Totacillin**<sup>®</sup> (ampicillin trihydrate)

**Pyopen**<sup>®</sup> (disodium carbenicillin)

**Bactocill**<sup>®</sup> (sodium oxacillin)

and more to come

**Beecham-Massengill  
Pharmaceuticals** **BMP**

Div. of Beecham Inc. Bristol, Tennessee 37620

- ☐ Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.
- ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
- ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

*Possible health insurance legislation can preserve the virtues of our system without uprooting it. Here the AMA's incoming President suggests how and why.*

## Countdown on National Health Insurance\*

Russell B. Roth, M.D., Erie, Pennsylvania

Perhaps I am abusing my status here as a panelist and invited guest but I do not like my assigned title—which reads “Health Care Insurance Act of 1971—Medicredit.” I do not propose to anatomize this bill. It would really be more in the nature of an autopsy, because the Health Care Insurance Act of 1971, and The Health Security Act of 1971 are all as dead and as irretrievable as is 1971 itself.

What I do want to do is to consider with you the fact that national disabilities in respect to the distribution of medical service are still with us, and that if our remedies have become outdated, or are being arbitrarily removed from the market, we need to consider what our new and future remedies may be.

I presume that there may well be an AMA-sponsored bill introduced into the 93rd Congress, just as there has been in the 91st and 92nd. If so, it will be an even better bill than its predecessors, because there has been no shortage of analysis and criticism of our bill, both constructive and destructive, and I trust we have learned from all of it.

Obviously there are, at the moment, imponderables which will duly become ponderables to be adjusted to. What will this Congress do with HR-1? Will there be something like the current Long catastrophic insurance provision in it? What will the Mills Bill really look like when it comes out of Committee? Can we support all of it, most of it, some of it, or none of it? These are practical pragmatic questions of importance if one is playing strategic games on Capitol Hill. But they cannot be dealt with except in speculative fashion right now, and I don't think you want my speculations. What I would like to share with you are my convictions. They are con-

victions as to basic principles which should be embodied in any medical service legislation if it is to have a chance to work, plus a few convictions as to how we may avoid the disaster which is inherent in some of the proposals which have been presented up to this point.

Will Durant and his wife Ariel have a fascinating little volume called “The Lessons of History” which bulges with delightful quotes. Let me borrow two. The first is that “Out of every hundred new ideas, ninety-nine or more will probably be inferior to the traditional responses which they propose to replace. No one man, however brilliant or well-informed, can come in one lifetime to such fullness of understanding as safely to judge and dismiss the customs or institutions of his society, for these are the wisdom of generations after centuries of experiment in the laboratory of history.” From this flows the second quote “So the conservative who resists change is as valuable as the radical who proposes it—perhaps as much more valuable as roots are more vital than grafts. It is good that new ideas should be heard, for the sake of the few that can be used, but it is also good that new ideas should be compelled to go through the mill of objection, opposition, and contumely; this is the trial heat which innovations must survive before being allowed to enter the human race.”

It has unquestionably been stimulating and good in the recent years to consider the many analyses of our problems in medicine, and to behold the many new ideas which have been proposed to solve them. It has no doubt also been good that the cumbersome and complex machinery of our legislative process has kept

\* Read before the American Society of Internal Medicine, April 15, 1972. Dr. Roth is President-Elect of the AMA.

us from compounding old mistakes or making new ones in a precipitous fashion.

First, let us look at the problem to be solved. In common with every other technological component of our society, medicine has been swept up in a revolution. From Hippocrates to Benjamin Rush the profession made some progress in learning more anatomy and physiology, but precious little about how to do useful things for sick people. Rush was still bleeding them of pints of much needed blood, or purging them to the brink of extinction—and both would be malpractice today. But suddenly true medical science exploded. Today we have a vast array of useful, and often very expensive things to do for people. But we have really gotten ahead of our capacity to do all these useful things for everybody—on the score of manpower—on the score of facilities—and on the score of finances. It has been said that if we halted research and development in their tracks—God forbid—we could spend the next ten years devoting all our resources to doing for those who need them all those helpful things we already know how to do. To call this a crisis is a peculiar perversion of a good medical term. There may be a financial crisis, but this is economics, not medicine.

Our problem, in short, is to understand the nature of the barriers which stand between our people who need useful medical services and those who have the competence to provide them. The barriers are still numerous, and some are most resistant to elimination. Once we understand them we may move intelligently to knock them down.

Here we run into our major difficulty. It is the conclusion reached by so many people unversed in the facts of life in medical practice that there is a swift simplistic solution. Just invent a new system for the provision of service, or educate twice as many providers of care, or appropriate a few more billion dollars to do the job—you have heard them all, and no one of them has the flimsiest chance of being the real answer. It follows that it is dangerously naive to put all the eggs in one

legislative basket—and the AMA has not made that mistake. Instead, having studied the components of the problem, it has attempted to make inventory of our resources—the men, women, and things that we have available—together with our capacities to augment these resources—and to set them to the task of doing the things that can be done.

First, we have no faith in radical restructuring of the system. Where medical care has been rigidly systematized it is generally in trouble, usually worse than ours. We can be thankful that we are the one major nation in the world that has not fallen into the trap. Sweden is deep within it, frantically struggling against financial disaster, and Swedish physicians are beginning to emigrate. Great Britain is in a different kind of trap and is now aware of it. J. Enoch Powell, the former Minister of Health in the MacMillan government now says that a quarter century of nationalized medicine has not given the British people more health services, more hospitals, or faster or necessarily better medical attention, and that no one should be looking for panaceas in nationalization which he refers to as a “fashionable folly.” In fact he says, “I happen to believe that the total resources devoted to medical care in Britain would be larger but for The National Health Service. I believe people would opt for more medical care than the state decides to allocate.” Note that well people would opt for more medical care than the state decides to allocate. When one contemplates the pressure of demand generated by our own people—and the reluctance of legislators to appropriate in Medicaid or for support of municipal hospitals and the like, it sounds important to us.

Focus upon a system is a delusion. Competent, conscientious, well-motivated physicians provide excellent medical service, whether it be under the socialized system of the Armed Forces or the Veterans Administration, or in prepaid comprehensive group practices, or fee-for-service groups, or in corporations, in partnerships, or in the solo settings. And if physicians aren’t competent or well-motivated it is naive to think that changing their system



will make them that way. It is spurious to hold that any valid answer lies in a restructuring of the system.

The AMA builds upon the successes of its flexible, adaptable, innovative, experimental non-system, or series of sub-systems. The demand upon us has generated from these successes—not from alleged failures.

There is a related delusion, often expressed by a slogan which says, "we must change from a system of sickness care to a system of Health Care." Great slogan, but it deserves a quick challenge. What do we change, and how do we change it? I recognize the immense superiority in keeping people well as against treating them when they are sick. And I am a practicing physician trained to diagnose disease and to treat it. For the many people who come to me and my associates with problems we try to understand them and to treat them, and to keep the problems from coming back. What does my theoretician actually propose that I do differently? To date no one has given me a sensible answer as to how I or we or you would really function differently in a Health Care Corporation, or a Health Maintenance Organization. The conversation trails off to talk about multiphasic health screening, or educational programs against overeating, overdrinking, overdrugging and under exercising. These are all fine things, generally to be done by less specifically trained individuals. They do not require revisions in the system. They require dedicated and generous support to the discipline of Preventive Medicine and Public Health with its programs and its research. Its accomplishments have added decades to the human life span in our century, whereas the entire spectacular field of organ transplantation has not yet added seven minutes across the board. The AMA supports Preventive Medicine, together with improvements in the environment, accident prevention, research in disease prevention, achievement of more and better immunizations, and would hit those things head on.

The AMA plan most assuredly will not seek to abolish the private health insurance industry.

It will not seek to abolish or restrict fee-for-service practices. It will be realistic about financing mechanisms—and most assuredly it will not make the mistake of taking that most extravagant, least efficient route of financing by extracting all the dollars as taxes, to make a round trip to Washington, support several vast bureaucracies on the way, and return as an emaciated, shrunken benefit.

I cannot tell you what may happen to the tax credit approach which has been a part of the Mediredit program. It makes good hard economic sense since it mobilizes a maximal number of dollars from the private sector from those who can pay all or a part of their medical care costs through insurance, and it keeps the inefficient tax dollar component as small as it can, but it has not been politically popular. It is infinitely superior to a direct increase in the social security type of payroll tax, and it is much simpler than the mandated employer-employee insurance approach which leaves so many problems in achieving uniform levels of coverage for the very small employer groups, the self-employed, the temporarily or permanently unemployed, the migratory worker, or other person employed by several employers, to say nothing of the uninsurables and the disabled.

Our concern with financing will be realistic, which has not characterized some of the other approaches. Senator Fred Harris is quoted as saying that if the Kennedy Bill is enacted he can foresee that the medical bill for the average family will be cut in half. I would submit that even Senator Harris, if he would **stop** really to think about it, would have to concede that if more medical service is to be provided for more people by more physicians in more and better facilities, with more allied medical assistants, using ever more sophisticated and expensive developments in diagnosis and treatment to bring about earlier recognition of disease with many longer and more expensive survivals, it is going to be more and more expensive, especially if inflation continues and labor costs keep going up, and even more especially if it is necessary to maintain a vast new bureaucracy to prebudget, negotiate

contracts, monitor and audit everything at national and regional and local levels.

The dangerous misconception that underlies this kind of political talk is a two-fold error in understanding. The first error is to presuppose that physicians' fees are a major component of the cost of medical services. They are not. The second error is to expect that capitation-financed comprehensive group practice is truly comprehensive and logically leads to increased productivity, greater accessibility, and a desirable decrease in utilization rates. These things just "ain't necessarily so."

At the present time approximately 13¢ of the medical care dollar ends up in the physician's pocket as income. Over the past decade if there had been no increase in physicians' fees whatsoever the over-all increase in medical care costs would have been close to its present order of magnitude. The preoccupation with physician fee profiles, the imposition of arbitrary percentiles on usual and customary fees, and the freezing of payment levels in some state Medicaid programs, have been generally of more harm than good. The selection of physicians as the villains in the piece has gone to the extent that the pay board has imposed discriminatory restrictions on the professional providers of medical and related services which smack of persecution, and the net result is largely to estrange physicians when the basic need of all federal medical programs is cooperation and support from the one group of people that can make federal programs, or any other medical care programs, work.

The AMA recognizes all this and would urge support from government, labor, management and consumer groups so that physicians may be helped to do the job of safeguarding the public purse. Physicians need to be better educated to their socio-economic role in acting as the purchasing agent for their patients of the goods and services of the medical care industry. They need to be better educated in the technics of peer review and the necessity to serve as reviewers and to be reviewed in constructive fashion. County and state medical societies, and the AMA, can contribute

greatly in these directions, which are the one great hope for proper cost containments.

Capitation-financed group practice used to be called contract practice back when the mines, the railroads, or the mills provided the medical service by salaried physicians in their own hospitals in company towns, financed by the check-off system. This system fell into general disrepute for a variety of good reasons. It was modified and revived by Dr. Sidney Garfield to grow into the Kaiser-Permanente program, and it has been further modified in a few other settings. Now it is being still further altered and it has been given the inept name of the H.M.O. or Health Maintenance Organization. Its principal concern is to treat illness and disability, but the Health Maintenance title has endowed it with charisma which it scarcely deserves.

In April 1972, in a conference in Florida, Dr. Ernest Saward, one of the great promoters of the Kaiser-Permanente principles, addressed himself to this uncritical enthusiasm for HMOs. He made it clear that no one is more genuinely concerned—or frightened—than the existing prepaid groups by the overpromise of the HMO promoters and the overexpectations of the consumers. He emphasized the clearly voiced misgivings of Dr. Garfield and other key people in the movement that there is nothing inherent in prepaid group practice which guarantees greater accessibility of care, more productivity per physician, lower cost per unit of service, or better quality of care.

Obviously there is much to be learned about the adaptability of contract practice. Can it be made truly comprehensive, or will there be large spillovers such as have been experienced by Kaiser-Permanente, HIP and the Labor Health Institute, to name some that have been studied in respect to the extent that beneficiaries go out of the system for significant amounts of care? Can the method be adapted to large expanses of territory with sparse population? Will it require more centralization of personnel and facilities or can it be decentralized? How will it subcontract or

otherwise coordinate with centers of excellence for scarce skills and services? Will the great medical centers be forced to change to meet geographical requirements or to become categorical centers? Can contract practices be developed to serve populations of the disadvantaged in center city, or will it be necessary to achieve a mix of a low income, high risk, high utilization population with some element of higher income and lower risk beneficiaries? If so, what should this mix be? How will such organizations recruit personnel and remain attractive to them, and how will they achieve consumer acceptance? All of these things should be known. Currently there are some 110 federal grants to underwrite planning and development of HMO's. One HEW estimate is that 50 per cent will never become operative, and that 25 per cent of those that do will fail. This will still leave about 40 experimental projects from which we ought to be able to learn most of the answers. The AMA favors such experimentation, and this seems to be quite an adequate sample.

It has long been clear in this country that in health and medical matters we grew up insuring the wrong end of the risk. It has always been the massive bills accumulating from serious or prolonged illness and disability which could plunge the individual or family into indigency. Relatively minor expenses at the front end of the risk could generally be met, one way or another. Unfortunately, labor has always insisted on first dollar coverage whenever it could get it. And yet coverage for the catastrophic end of the risk is the least expensive to buy. The AMA program will almost certainly include a major medical catastrophic feature built on a sound basic coverage, in order to correct this general deficiency. The AMA does not feel that a free-standing catastrophic program is sound, equitable or administrable, but clearly what the AMA bill will do about this depends on the shape of HR-I as it may be passed in this Congress.

The AMA proposal in my mind will continue to be a composite of many inter-related programs. A financing component will provide for putting an insurance policy or contract

within reach of everyone, with emphasis on private financing for those able to meet the cost *in toto* or in part, with federal revenues to meet the rest. There will be basic coverage for physicians' services wherever rendered, for out-patient ambulatory care services, for in-hospital services, and with elements of extended care service, dentistry, prescription drugs and the like still negotiable in terms of how much Congress is willing to afford. There will be catastrophic coverage on the top. Federal administration will be kept minimal.

In addition, we will adjust to the necessities in respect to peer review legislation, depending again on the final provisions of HR-I, which may strike us as being in need of amendment or even repeal, if they are too unrealistic. Peer review is scarcely in shape to be legislated upon us in any form, but we will continue to try to be constructive—hopefully even more constructive than in the past.

We will continue to promote professional medical education and the education of allied medical personnel, with the development of new kinds of skills. We will continue our pioneering work in establishing curricula, in developing criteria for certification as to competence, and related matters.

We will continue to speak out with as objective and authoritative a voice as we can command when legislative proposals are offered in the medical care field. We will work with renewed effort to suppress quackery despite the insistence of so many of our legislators to support it. We oppose chiropractic in Medicare and Medicaid and anywhere else.

All these things and more will be the AMA program for next year and the years to come, and I trust we shall continue to avoid the compulsion to wrap them all together in one piece of legislation.

Fundamentally we shall work through all available channels, legislative and otherwise, to ensure that our physicians are competent, conscientious, and well-motivated. It is the best possible contribution for our people.



ALSO AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

**Android<sup>®</sup> 5** MUQUETS  
BUCCAL Tabs  
**Methyltestosterone N.F. - 5 mg.**

**Android<sup>®</sup> 10**  
**Methyltestosterone N.F. - 10 mg.**

**Android<sup>®</sup> 25**  
**Methyltestosterone N.F. - 25 mg.**

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchidism	30 mg.

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

**BROWN**

**THE BROWN PHARMACEUTICAL CO., INC.**  
2500 West 6th Street, Los Angeles, California 90057

---

# NEW JERSEY DOCTORS' NOTEBOOK

---

## Trustees' Minutes

October 15, 1972

A regular meeting of the Board of Trustees was held on October 15, 1972, at the Executive Office in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

*Standards for Licensure of Home Health Agencies . . .* Designated (in response to a request from the Licensure Committee of the New Jersey Department of Health) David Eckstein, M.D., to serve as MSNJ representative on the State Committee to Develop Standards for Licensure of Home Health Agencies—the State Department of Health will be responsible for licensing.

*AMA Delegates . . .* Directed that a communication be sent to the Presidents of County Societies urging their cooperation in assisting MSNJ to increase AMA membership from New Jersey. Presently membership is below 5,000; unless it increases to above that number by December 31, 1972, MSNJ will be unable to retain its sixth delegate to the 1973 meetings of the AMA House of Delegates.

*MSP Complaints on Fees . . .* Accepted the following report presented by Joseph P. Donnelly, M.D., concerning MSP's justification for writing to physicians alleging they were billing for additional services above the fees being accepted by their peers for similar services, and directed that MSP be requested to express in writing its willingness to submit to and abide by the findings of peer review under the judicial mechanism.

The purpose of the Prevailing Fee Program was to substitute for a fixed-fee program, with income levels, a program which would pay a physician his usual charges up to the usual, customary, and reasonable charges of physicians of similar competence in a similar socio-economic area. This concept was adopted by the House of Delegates in 1967 and again re-examined and approved in 1968. To arrive at a ceiling

for the usual, customary, and reasonable charges of physicians, every practicing physician in the State of New Jersey was asked to submit a profile for his usual charges for the services he performed most frequently according to his specialty. Surprisingly enough, over 80 per cent of the physicians submitted surveys, and the top of the range for the different services in each specialty was set at a figure which covers the usual charges of 90 per cent of the physicians for that particular service. Oftentimes it covers over 95 per cent of the physicians, and about 99 per cent of the payments under the Plan have been accepted by physicians as payment in full for their services. The charges of non-participating physicians who had prior agreements with their patients were not expected to be governed by the Prevailing Fee Program.

Up to now we have paid over one million claims under the Prevailing Fee Program. We have given legal assistance to patients only three times, and this only when the physician instituted a suit for a balance bill and the subscriber and physician had no prior agreement for an additional payment. Some eight cases have been referred to the judicial mechanism. The only question we are asking of judicial committees on behalf of our subscribers is whether or not a physician's charges were excessive and above the usual, customary, and reasonable fee in his socio-economic area.

Contrary to rumors being circulated, Blue Shield is not looking for excuses to sue doctors but would prefer, as recommended by the AMA and The Medical Society of New Jersey, to settle these disputes by peer review. In the letters which were sent to you by two physicians and forwarded to the Plan, the doctors protested three things which we had written in the letters.

1. That "payments under the Prevailing Fee Program are up to the usual and customary charges of physicians in your specialty practicing in a similar socio-economic area."

The answer to that is that the profiles of similar physicians clearly show that the usual charges of doctors in his area were equal to or below the ceiling of the Prevailing Fee.

2. They objected because we said we would prefer to settle the matter by peer review of the judicial committee of the county society.

The Plan, of course, prefers peer review to legal action and will never institute suit against the doctor in this type of case and will abide by the decision of peer review.

3. The doctors also objected to the statement, "if you choose not to use a judicial mechanism by referral of the balance of your bill to a collection agency or by threats of litigation, the Plan has no recourse except to notify such agency that no payment can be made, under our Enabling Act, which is greater than that paid to a participating physician without a judgment obtained in a court of law."

It should also be understood that a letter of this type is never sent until the physician has been contacted by the professional relations staff and also by our medical staff in attempts to settle a dispute.

At a special meeting of the Blue Shield Fee Committee on October 3, which included ten physicians as well as several other members of the Board, the letter from the Medical Society was reviewed, as well as the letter to the physicians which initiated the controversy. After prolonged discussion, the Committee approved the draft of a new letter which will be sent to physicians before a case is referred to a judicial committee on behalf of the patient. There is no great change in the intent of the letter but we believe some objectionable phrases have been removed. We hope this meets with your approval.

I would like to say at this time that the objections to the Prevailing Fee Program which result in peer review or legal action have occurred approximately twenty times in a million claims, and come from considerably less than one-half of one per cent of the practicing physicians in New Jersey. I do not believe I am making a false statement when I say that all the physicians in New Jersey prefer the Prevailing Fee payments over the payments in the old contract. The Prevailing Fee has been continually updated to be sure the top of the range reflects the practicing physicians' charges. This has resulted in an increase of over 12 per cent in the United Auto Workers premium of 1969 to 1971. The cooperation of the Medical Society and its judicial mechanism is urgently needed to assure all purchasers of the Prevailing Fee Program that the increase in premiums will not rapidly outstrip the cost of living index. The price of freedom for both provider and insurer is public accountability. Peer review provides the mechanism for such public accountability.

*Joint Conference of Presidents and Presidents-Elect . . .* Met with members of the Conference of County Presidents and Presidents-Elect, representing 20 counties, and discussed the following items: (1) Society-sponsored group automobile insurance—the conferees questioned the desirability of such a program; (2) public relations—conferees recommended employment by MSNJ of full-time public relations counsel who would also assist the counties in their public relations activities; (3) physicians' complaints with third party carriers—the Board pointed out that the following MSNJ committees are at the disposal of physicians for reviewing such complaints: Advisory Committee to Review MSP and HSP Disputed Claims, Joint Medicare Claims Inquiry Committee, Medicaid Peer Review Committee, Medicare Peer Review Committee, and the Negotiating Committee for Medicaid; (4) Medicare arbitrary judgment on necessary claims—conferees felt that determination of medical care should be a function of the attending physician and not determined by post-discharge review by third party carriers; (5) abolishment of contingency fees in malpractice cases; (6) reception for President-

Elect at annual meeting; (7) health maintenance organizations; (8) special session of the House of Delegates; (9) AMA membership—conferees were asked to support MSNJ's efforts to increase AMA membership by December 31, 1972 so that MSNJ will not lose its sixth AMA Delegate to the 1973 meetings of the AMA House of Delegates.

*Section on Emergency Medicine . . .* Advised that a request (from the Chairman of the Committee on Emergency Medical Care) that MSNJ submit a resolution to the AMA House of Delegates at the Clinical Convention urging the formation of a Section on Emergency Medicine for the purpose of coordinating educational programs for all practicing physicians be brought to the attention of MSNJ's 1973 House of Delegates either by means of a resolution or through a recommendation in the annual report from the Committee on Emergency Medical Care.

*Foundation Approach to Medical Care . . .* Accepted a progress report from the Core Committee on the Foundation Approach to Medical Care and authorized a meeting on November 12 of that Committee and the presidents of the component societies and secretaries of specialty societies. The deliberations of the committee have resulted in the following courses of action: (1) agreement that the best foundation plan is the "Twin Cities" or "Hennepin County Plan;" (2) compilation of a constitution and bylaws for such a foundation which it considers in harmony with New Jersey state statutes (3) assurance of the cooperation, including financial support for administrative costs, of the Health Insurance Council; (4) unofficial assurance of support by Blue Cross and Blue Shield on the same basis; (5) scheduling of meetings with the Hospital Association and the State Peer Review Committee; (6) scheduling of a meeting on November 12 with county society presidents and specialty society secretaries; and (7) decision to request the MSNJ House of Delegates (at its meeting on December 10) to vote the sum of \$80,000 as an endowment for the foundation.



# Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during October 1972:

	1972 October	1971 October
Aseptic meningitis	47	33
Post-infectious encephalitis	0	1
Hepatitis: Total	236	445
Infectious	187	315
Serum	49	130
Malaria: Total	1	16
Military		11
Civilian	1	5
Meningococcal meningitis: Total	2	11
Military	1	0
Civilian	1	0
Mumps	28	19
German measles	3	10
Measles	10	4
Salmonella	112	130
Shigella	27	40

## Foodborne Outbreaks

Four separate and instructive foodborne outbreaks have occurred in recent weeks. One was the first documented outbreak caused by *Vibrio parahaemolyticus* in New Jersey; another was caused by salmonella contaminated meat products, and the other two were staphylococcal.

Illness caused by *Vibrio parahaemolyticus* has been recognized only recently in the United States. The organisms are commonly found in seafood, particularly crabs. In the United States, Maryland crabs have been the cause of several outbreaks, although shrimp was involved in an outbreak in Louisiana. Frequently, cooked crabs are contaminated when placed back into the baskets in which raw crabs were

shipped. In the New Jersey outbreak, 12 people became ill with typical symptoms of abdominal cramps and watery diarrhea about 24 hours after eating seafood. Crabs were probably the contaminated food although shrimp cannot be absolutely ruled out. *Vibrio parahaemolyticus* was cultured from sides of the shipping containers.

The *Salmonella* foodborne outbreak was traced to a meat-producing plant in Linden. Some of the patients had as many as three separate salmonella serotypes in their stool specimens. *Salmonella* was found in head cheese and boiled ham. It was probably brought into the plant by contaminated hog stomachs used as casing for the head cheese.

Two staphylococcal foodborne outbreaks occurred in public schools. In one, hot turkey sandwiches were the responsible vehicle. Two hundred and fifty students became ill with typical symptoms of staphylococcal food poisoning. The turkey had been prepared about four days prior to serving which allowed ample opportunity for staphylococci to proliferate. In the other school about 200 students became ill with stomach pain, nausea, and vomiting after eating roast beef. The roast beef had been sliced on the day of the meal, and after slicing was placed in a warmer at 140° for 2 to 3 hours. Interestingly, the same roast beef was served at a different school, but was sliced just prior to serving. No illness occurred. In both staphylococcal foodborne outbreaks, errors in food preparation coupled with excessive time in preparation allowed for staphylococci to proliferate.

## The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance

to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

"Prescribe With Confidence"

K A T E S   B R O S .

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

*Barefoot to Freedom*

SOLD ON Rx ONLY

CORRECTIVE FOOTWEAR FOR MEN • WOMEN • CHILDREN

OUTFLAIR SHOES FOR CLUB FEET

400 MAIN STREET

HACKENSACK, N. J.

201-487-1779

Dennis Brown Splints — In all sizes — Carried in stock  
CUSTOM SHOE SHOP ON PREMISES

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY  
FORGETFULNESS • CONFUSION



**Cerebro-  
Nicin<sup>®</sup>** CAPSULES

**A GENTLE CEREBRAL  
STIMULANT & VASODILATOR  
FOR GERIATRIC PATIENTS**

**CEREBRO-NICIN<sup>®</sup> double-blind study\***  
shows how some senile symptoms can be treated.  
Four times as many aging patients showed  
striking improvement.

Each CEREBRO-NICIN capsule contains:  
Pentylentetrazole .....100 mg. • Nicotinic Acid ....100 mg.  
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.  
L-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.  
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.

AVAILABLE: Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.

**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

**CONTRAINDICATIONS:** Epilepsy or low convulsive threshold.

**CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .  
**BROWN THE BROWN PHARMACEUTICAL CO.**  
2500 W. 6th St., Los Angeles, Calif. 90057

\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D.  
Double-blind study on the treatment of mentally confused patients. Reprinted  
from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

## Medical College Notes

Stanley S. Bergen, Jr., M.D.  
President, CMDNJ

### Maternal and Infant Care Project

A look at the health statistics for mothers and newborn infants in Newark offers a challenge to each of us. In our state's largest city, the infant mortality rate in 1970 was 32.5 per 1,000 live births (New Jersey rate, 20.0; USA average rate, 18.4) and the prematurity rate was 12.3 per 1,000 live births (New Jersey rate, 8.2 in 1969). A report by the Center for Analysis of Public Issues on health conditions in Newark stated that one of every 19 deliveries to Newark mothers in 1970 (or six per cent) resulted in death of the fetus or child, before age one. In New Jersey as a whole the comparable figure was only 3.4 per cent.

To combat these grim statistics the Maternal and Infant Care (MIC) project of the College of Medicine and Dentistry of New Jersey—New Jersey Medical School—is providing specialized comprehensive pre and post natal care, without cost, to nearly six hundred pregnant young women yearly, as well as pediatric care for their infants. The project is funded by HEW and the College.

MIC's clinic is at 877 Broad Street in the heart of downtown Newark, convenient to public transportation. It is in an office building, without the stigma of being obviously a clinic for unwed mothers. The clinic has five examination rooms, a pharmacy, dental clinic, and two large meeting rooms, as well as interview rooms for nutrition and social service counseling.

Considered "high risk" in pregnancy because of their youth, the young women being served by the MIC project have additional problems to overcome: poor nutrition and inadequate health care, lack of knowledge of sexuality and reproduction, an interrupted education, a stress-filled environment, and, in some cases, ostracism by family and friends.

To thwart these physical, emotional, and environmental factors, MIC provides regular prenatal care; extensive patient education in pregnancy, labor, and delivery; dental care; nutrition education and counseling; social service support; and free prescription drugs. Following delivery, MIC patients receive postpartum six week check-ups and the opportunity to begin some method of family planning. Their infants receive all necessary pediatric care, including immunization, to age one. Nutrition and social services, and dental counseling and care are continued during this period.

A substantial portion of the young women helped by MIC come in during the first and second trimesters of pregnancy; thus the staff may have as long as eight months to provide service and support, and hopefully, to bring about positive changes in the patient's life style.

Perhaps the largest stumbling block in the path of MIC's ultimate success is getting the girls to come to the clinic in the first place. We are planning a publicity campaign. Until now, knowledge of the clinic's existence has been largely confined to word of mouth and referral by school nurses. A brief phone call is enough to get started in the project and the first visit leads directly into the program of health care and education.

The program has been developed by Harold A. Kaminetsky, M.D., acting dean of the College of Medicine and Dentistry of New Jersey—New Jersey Medical School—and project director of MIC. L. W. David, M.D., assistant professor in the Department of Obstetrics and Gynecology at the New Jersey Medical School is associate project director.

Registration for the project is from 8:30 a.m. to 3 p.m. Monday through Friday. An appointment can be arranged through the service phones, 643-8326 and 643-8327. Specific questions will be answered by the director of nursing, Miss Emily White, who can be phoned at 643-2808.



## Long-Term Survival Rates in Cancer

A report of the National Cancer Institute indicates a substantial betterment in patient survival in some forms of the disease.

The fourth annual "End Results in Cancer" was prepared by the Institute-sponsored "End Results" group. It summarizes the survival experience of patients diagnosed with cancer from 1940 through 1969 in more than 100 hospitals. Varying survival rates up to 15 years are given for each form of cancer.

<i>Types of Cancer</i>	<i>3-Year Survival 1940-49</i>	<i>3-Year Survival 1965-69</i>
Bladder	48%	62%
Brain	28	37
Chronic lymphocytic leukemia	33	53
Larynx	47	67
Melanoma of the skin	49	74
Multiple myeloma	10	27
Prostate	49	66
Thyroid	67	86

Other cancers for which there have been important increases in patient survival since the 1940's are childhood leukemia, Hodgkin's disease, and breast cancer. The one-year survival rate for children under 15 with leukemia has increased from 36 per cent in 1955-64 to 59 per cent in 1965-69. Among children with acute lymphocytic leukemia, the three year survival rate has increased from less than 6 per cent to 15 per cent over the past 10 years. Twenty years ago only 35 per cent of Hodgkin's disease patients survived three years; among patients diagnosed in 1965-69, 61 per cent survived three years. For all stages of breast cancer the three year survival rate has increased from 63 per cent 20 years ago to 72 per cent in the most recent time period. Of the patients with localized disease diagnosed during 1965-69, 91 per cent were alive three years after diagnosis.

However, there has been little or no improvement in life expectancy for patients with lung cancer and cancer of the pancreas. Lung malignancy is the most common male cancer with 62,000 new cases and 56,000 deaths annually in the U.S.A. The incidence is still increasing. For all lung cancer, the three year

survival rate is only 11 per cent; for localized disease, the three year rate has increased from 17 per cent in the 1940's to 39 per cent in 1965-69.

Survival rates for cancer of the pancreas have shown no improvement over the past 20 years. Its incidence has risen from 7 cases per 100,000 persons to 9. Some 19,000 new cases are diagnosed each year in the United States. Over 90 per cent of these die within one year. The three year survival rate of the 1940's was 2 per cent, for all stages of this disease. Even when detected in the early stages, the three year survival rate is still only 4 per cent.

Women survive longer after cancer diagnosis than men. Only 31 per cent of men with cancer survive five years or longer while 42 per cent of women patients live 10 years or more. This pattern holds true for localized as well as for all stages of cancer.

Surgery is the most-used form of treatment. During the recent period, 55 per cent of all patients were treated by surgery, 29 per cent by radiation and 18 per cent by chemotherapy. Although surgery has remained the treatment of choice in recent years, more patients are receiving radiotherapy (34 per cent) and chemotherapy (22 per cent).

There has been an encouraging increase in the proportion of cancers of the breast, prostate, bladder, and brain, and melanoma of the skin being diagnosed while localized. Breast cancers localized at diagnosis have increased from 38 per cent to 47 per cent in the past 20 years; for prostatic cancer, the proportion localized has increased from 49 to 63 per cent in the same time period.

Women with cancers of the cervix and body of the uterus have a good outlook for survival. The three year survival rates for women with early disease are 82 per cent for cervix and 88 per cent for the body of the uterus. For all stages, long-term survivals are also encouraging, with 10-year survival rates of 55 per cent for women with cervical cancer and 69 per cent for patients with cancer of the body of the uterus.

---

**207th Annual Meeting**  
**The Medical Society of New Jersey**  
**May 12-15, 1973**  
**Haddon Hall, Atlantic City**

**Daily Schedule**

**Friday, May 11, 1973**

4:00 p.m. — Board of Trustees

**Saturday, May 12, 1973**

9:30 a.m. — Registration Opens  
12:00 noon — Exhibits Open  
2:00 p.m. — House of Delegates  
2:00 p.m. — Motion Picture Theatre  
3:00 p.m. — Reference Committees ("A", "B", "D",  
"G", and Const. and Bylaws)  
5:00 p.m. — Nominating Committee  
7:30 p.m. — Officers' Dinner (by invitation)  
7:30 p.m. — Reception/Buffer/Dancing

**Sunday, May 13, 1973**

9:00 a.m. — Registration and Exhibits Open  
9:30 a.m. — Scientific Sessions  
10:00 a.m. — Motion Picture Theatre  
10:00 a.m. — Reference Committees ("C", "E", "F",  
and "H")  
1:00 p.m. — Scientific Sessions  
2:00 p.m. — Motion Picture Theatre  
3:30 p.m. — House of Delegates (election)  
Addresses of President and President-Elect  
4:30 p.m. — Golden Merit Award Ceremony  
6:30 p.m. — Inaugural Reception  
8:00 p.m. — Inaugural Dinner (by invitation)

**Monday, May 14, 1973**

9:00 a.m. — Registration and Exhibits Open  
All Day — Scientific Sessions  
10:00 a.m. — Motion Picture Theatre  
2:00 p.m. — Motion Picture Theatre  
3:00 p.m. — House of Delegates  
5:00 p.m. — Exhibits Close  
8:00 p.m. — Annual Dinner—Dance

**Tuesday, May 15, 1973**

9:00 a.m. — Registration Opens  
9:00 a.m. — House of Delegates  
12:00 noon — Registration Closes  
8:00 p.m. — Board of Trustees

---

**The Scientific Exhibits — —**  
**207th Annual Meeting**

The following information is pertinent to the scientific exhibit display at the 207th Annual Meeting of this Society, May 12 to 15, 1973. Those interested in participating may use the application form on page 973. (Please complete both sides.) Remove the page from *The Journal* and mail directly to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

*Policy*—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

*Space* assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will not be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

*Application for space* in the Scientific Exhibit must be submitted no later than January 1, 1973, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to John J. Thompson, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton 08605.

1. *Time*: The exhibits will open officially at 12 noon, Saturday, May 12, and close at 5 p.m., Monday, May 14. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling*: Installation of exhibits may begin at 3 p.m., Friday, May 11, and all exhibits must be in place by 11 a.m., Saturday, May 12. Exhibits must remain intact until 5 p.m., Monday, May 14, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 15.

3. *Cost*: The Society provides free of charge such space exhibitor may require including booth with shelf, printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections*.

4. *Sponsorship*: All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space*: No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles*: Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising*: No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations*: All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures*: Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent*. The exhibitor must supply his own screen, projector, and operator.

10. *Liability*: It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards*: Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission*: Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.



# THE MEDICAL SOCIETY OF NEW JERSEY

## 207th Annual Meeting

HADDON HALL

ATLANTIC CITY, NEW JERSEY

### APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 12-14, 1973

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use typewriter, or print, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

.....

.....

.....

.....

.....

3. Is the exhibit free-standing or self-contained? .....

4. SIGN required: ..... SIGN not required: .....

5. Will backwall and dividers be required? (see sketch on reverse side): .....

6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....

7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. ....

8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: .....

Return application to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey,  
P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

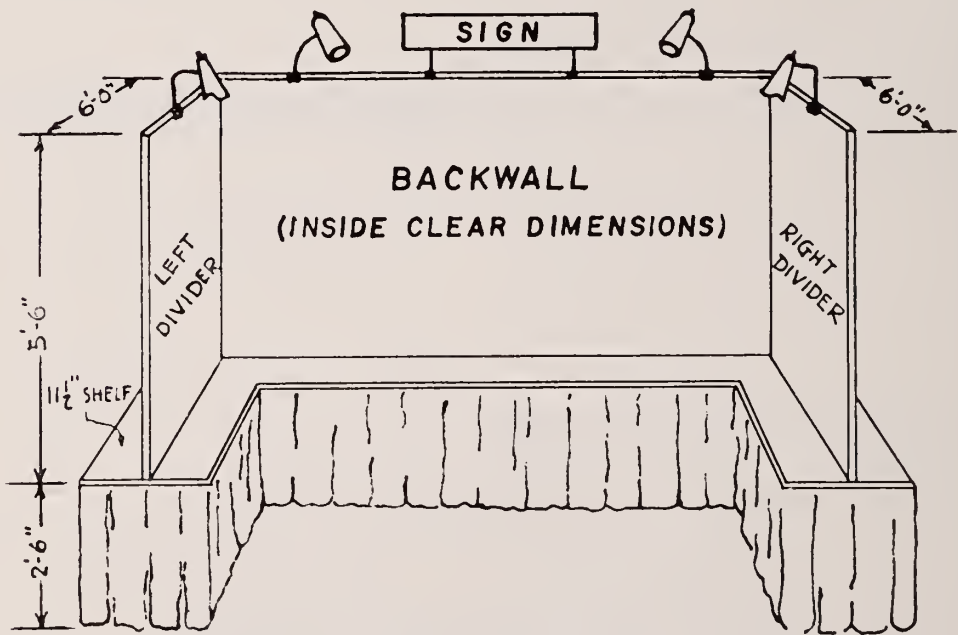
# STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

## ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Overhead lights	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

If your exhibit will not require backwall, or left or right dividers, please advise.  
If a sign is incorporated with your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

# PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.*

**ANESTHESIOLOGY**—Celia Mencado Sagullo, M.D., 138 Terrace Place, Brooklyn, New York 11218. Manila 1963. Board eligible. Group or partnership. Available.

Myung S. Lee, M.D., 35-44 28th Street, Astoria, New York 11106. Ewha University (Korea) 1964. Board eligible. Group or solo. Available January 1973.

**CARDIOLOGY**—Paul Goldfinger, M.D., U.S. Navy Hospital, Department of Cardiology, Portsmouth, Virginia 23708. George Washington, 1966. Board certified (IM), Board eligible (C). Group, partnership, hospital. Available July 1973.

Richard H. Landesman, M.D., 477 Comstock Place, Highland Park, Illinois 60035. Vermont 1966. Board certified (IM). Group, partnership, hospital. Available July 1973.

**FAMILY PRACTICE**—Biagio Scialpi, M.D., 156 Caryl Avenue, Yonkers, New York 10705. Bari (Italy) 1949. Group, associate, solo. Available.

Suresh C. Doshi, M.D., Box 212, Oceana Medical Center, Oceana, West Virginia 24870. Bombay (India) 1961. Partnership or other. Available July 1973.

**GASTROENTEROLOGY**—Kambiz Azmudeh, M.D. 6255 Broadway, Bronx, New York 10571. Tehran 1964. Board eligible. Group or partnership. Available.

Ernest T. Bajpai, M.D., 250 Beverly Boulevard, Apt. F-105, Upper Darby, Pennsylvania 19082. Prince of Wales (India) 1955. Board eligible. Group or full-time salaried. Available July 1973.

Eugene F. Cheslock, M.D., 107 Beverwyck Drive, Guilderland, New York 12084. New Jersey Medical 1965. Subspecialty hematology. Board eligible. Group or hospital.

Cesar Soriano, Jr., M.D., 320 East Chestnut Street, Coatesville, Pennsylvania 19320. Santo Tomas (Philippines) 1965. Board eligible. Group, associate, partnership. Available.

**GENERAL MEDICINE [INDUSTRIAL]**—James C. Mitchell, M.D., Millside Manor, #1-E, Delran, New Jersey 08075. Medical College of South Carolina 1961. Board eligible. Subspecialty, urology. Prefer work in industry in South Jersey. Available January 1973.

**INTERNAL MEDICINE**—Noorollah Kashani, M.D., 107 New Street, East Orange 07017. Tehran 1966. Board eligible. Subspecialty gastroenterology. Association or partnership. Available.

Alfred M. Detrow, M.D., 16 Crawford Drive, Dix Hills, New York 11746. Tults 1962. Subspecialty, nephrology. Board certified. Group or partnership. Available early 1973.

**NEUROLOGY**—Richard M. Sax, M.D., 3541 East Glencoe Street, Coconut Grove, Florida 33133. Louisville, 1968. Board eligible. Group or partnership. Available 1973.

Robert H. Friedman, M.D., 1249 Park Avenue, Apt. 17-B, New York, New York 10029. Jefferson 1969. Board eligible. Group, partnership, associate, or solo. Available July 1973.

Manuel A. Caddac, M.D., Department of Neurosurgery, Naval Hospital Boston, Chelsea, Massachusetts 02150. St. Tomas, Philippines 1962. Board eligible. Solo, group, partnership, or teaching. Available June 1973.

**OBSTETRICS-GYNECOLOGY**—Charles J. Seigel, M.D., 217-10 Lexington Boulevard, Clark, New Jersey 07066. Pittsburgh 1967. Board eligible. Group or partnership. Available July 1973.

Jae-hak Choe, M.D., 481 8th Avenue, New York 10001. Kwangju (Korea) 1965. Board eligible. Associate, group, or partnership. Available July 1973.

Sangkyu Shin, M.D., 2502 Alter Road, Detroit, Michigan 48215. Yonsei (Korea) 1965. Group or associate. Available July 1973.

Mircea Veleanu, M.D., 9111 Church Avenue, Apt. 4-L, Brooklyn, New York 11236. Hadassah (Israel) 1964. Board eligible. Group or partnership. Available July 1973.

Arthur Howard, M.D., 6729 Doolittle Drive, Edwards AFB, California 93523. Hahnemann 1967. Board eligible. Partnership. Available July 1973.

**OPHTHALMOLOGY**—Robert Heidenry, M.D., Route 6, Box 198-4, Port Orchard, Washington 98366. St. Louis 1967. Group or partnership. Available July 1973.

**ORTHOPEDICS**—Rother A. Bronfman, M.D., 8702 Pennsbury Place, Apt. 2, Richmond, Virginia 23229. New Jersey Medical 1966. Board eligible. Solo, partnership, group. Available July 1973.

Frank G. Guellich, M.D., Valley Forge Army Hospital, Phoenixville, Pennsylvania 19460. New Jersey Medical 1966. Board eligible. Solo or partnership (Mercer, Morris, or Somerset Counties). Available July 1973.

T. K. Kobayashi, M.D., 812 Woodside Drive, Iowa City, Iowa 52240. Colorado 1966. Board eligible. Group or partnership. Available July 1973.

Yeshawant V. Ginde, M.D., 149 Nighbert Avenue, Logan, West Virginia 25601. Bombay (India) 1961. Board eligible. Group, partnership, or hospital. Available January 1973.

Larry Katz, M.D., 244 Fieldston Terrace, Apt. 4-L, Bronx, New York 10471. Temple 1968. Board eligible. Solo, partnership, or group. Available July 1973.

Surrender M. Grover, M.D., 89 Park Avenue, Newark 07104. MA Medical (India) 1966. Group, solo, or partnership. Available July 1973.

Ching-Jen Wang, M.D., 435 Hanover Avenue, Staten Island, New York 10304. Taiwan 1965. Board eligible. Partnership, group, solo. July 1973.



**OTOLARYNGOLOGY**—George W. Hicks, M.D., 6139 Broadmoor Plaza, Indianapolis, Indiana 46208. St. Louis 1967. Board eligible. Group, partnership, association. Available July 1973.

**PATHOLOGY**—Horn Min, M.D., 35-44 28th Street, Astoria, New York 11106. Seoul University (Korea) 1961. Board certified. Group or partnership. Available January 1973.

Mark A. Cohan, M.D., 5407 Greenfield Drive South, Portsmouth, Virginia 23703. Western Reserve 1966. Board certified AP and CP. Group or associate. Available July 1973.

**PEDIATRICS**—N. Boramanand, M.D., 331 East 29th Street, Apt. 14-P, New York, New York 10016. Birmingham (England) 1965. Subspecialty, pediatric neurology. Board certified. Group, partnership, association. Available July 1973.

Barton W. Kaplan, M.D., P.O. Box 741, 4108 Hyde Park Drive, Chester, Virginia 23831. Upstate Medical Center (Syracuse) 1968. Special interest, developmental problems. Board eligible. Group, partnership, or association. Available July 1973.

J. S. Bharara, M.D., Monmouth Medical Center, Long Branch 07740. Amritsar (India) 1961. Board eligible. Group or partnership. Available.

K. Bhujanga Rao, M.D., 5501 North 11th Street, Apt. 404, Philadelphia, Pennsylvania 19141. DCH (India) 1961. Board eligible. Group. Available January 1973.

**SURGERY**—Michael J. Attkiss, M.D., 23 Hemlock Road, Newton, Massachusetts 01264. Columbia 1964.

Group, partnership, solo, hospital, teaching. Available July 1973.

Nestor M. Sagullo, M.D., 138 Terrace Place, Brooklyn, New York 11218. Manila 1963. Board eligible. Solo or partnership. Available.

Mabini C. Piezas, M.D., 2401 Pennsylvania Avenue, Apt. 8-A-6, Philadelphia, Pennsylvania 19130. Southwestern (Philippines) 1964. Board eligible. Group or partnership. Available.

Ron Lapin, M.D., 950 49th Street, Brooklyn, New York 11219. Indiana 1968. Subspecialty, vascular surgery. Board eligible. Solo, partnership, or group. Available July 1973.

**UROLOGY**—Eugene J. Lind, M.D., 4B Collins Street, Westover Air Force Base, Massachusetts 01022. NYU 1966. Board eligible. Partnership or group. Available August 1973.

Franklin A. Morrow, M.D., 1 Wall Street, Fort Lee, New Jersey 07024. New York Medical 1966. Board eligible. Association or solo.

Marvin S. Wetter, M.D., 70-35 260th Street, Glen Oaks, New York 11004. Jefferson 1966. Group or partnership. Available July 1973.

J. G. Besai, M.D., 52 East Maple Street, Teaneck 07666. Bombay (India) 1958. Board eligible. Solo or association. Available.

Man Mohan Gursahani, M.D., 1427 Peacock Lane, Brentwood, Missouri 63144. India 1964. Board eligible. Group, partnership, or solo. Available July 1973.

## INFORMATION FOR READERS AND CONTRIBUTORS

*The Journal*, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

*Change of Address:* Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

*Communications:* Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

*Contributions:* Manuscripts submitted to *The Journal* must be typewritten, double-spaced on letter size (about 8½ by 11 inch) paper, and

forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not, and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit an original and one copy and are urged to keep a carbon for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

*Illustrations:* Authors wishing illustrations for their articles will submit glossy prints or original drawings from which cuts can be made. The cost of making such cuts will be borne by the author, who may, after publication, receive the cuts for his own use—if he makes such a request in writing to the Editorial Offices.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

---

# ANNOUNCEMENTS

---

## Clinical Application of Basic Sciences

The December 1972 and January 1973 programs for the Burlington County Memorial Hospital's series on the clinical application of the basic sciences have been announced as follows:

- |             |   |
|-------------|---|
| December 7  | Thrombophlebitis and Thromboembolic Diseases    |
| December 14 | Anticoagulant Therapy                           |
| January 4   | Portal Hypertension                             |
| January 11  | Peptic Ulcer                                    |
| January 18  | Liver Injury—Its Relation to Clinical Pathology |
| January 25  | Myeloproliferative Disorders                    |

All lectures, which are supported by educational grants from Merck, Sharp, and Dohme, are presented at the T. J. Summey Building across from the hospital and convene promptly at 3:30 p.m. The American Academy of Family Practice gives one and a half credits per session. Further information is available from the Department of Medical Education of the hospital (175 Madison Avenue, Mount Holly).

## Psychiatric Graduate Programs

Under the cosponsorship of the Academy of Medicine of New Jersey, Fair Oaks Hospital in Summit announces the following schedule of continuing education programs. All sessions convene at 3 p.m. on the days indicated.

- |             |  |
|-------------|--|
| December 13 | Hypnosis in Psychiatry—Clinical Cases<br>Habiba A. Koblenzer, M.D. |
| January 4   | Drug Addiction<br>Edward Wolfson, M.D.                             |
| January 17  | Proper Use of Antibiotics<br>Dominic A. Mauriello, M.D.            |
| February 1  | Neurologic Syndromes in Psychiatry<br>Eugene W. Loeser, M.D.       |
| February 14 | Medical-Surgical Emergencies in Psychiatry<br>Seymour Kuvin, M.D.  |

The hospital is located at 19 Prospect Street. For further information, please write to Granville L. Jones, M.D., Director of Research and Education, Fair Oaks Hospital, Summit, New

Jersey 07901. Future programs will appear in later issues.

## Radiologic Seminars

Additional programs in the Rutgers Medical School (CMDNJ) series of seminars in radiology are as follows:

- |             |   |
|-------------|---|
| December 13 | Benign Bone Tumors<br>Meyer Alpert, M.D.<br>Franklin General Hospital                                 |
| January 17  | Vascular Aspects of Scleroderma<br>William J. Casarella, M.D.<br>Columbia-Presbyterian Medical Center |
| February 14 | Radiology Data Acquisition Systems<br>Mrs. Dorothea Aronson<br>Milton S. Hershey Medical Center       |

Meetings are held the third Wednesday of each month and convene at 5 p.m. in Link Room 203 at the Basic Science Building, Rutgers Medical School, New Brunswick. There is no fee. Additional information is available from Charles P. diLiberti, M.D., Raritan Valley Hospital, 257 Greenbrook Road, Green Brook, New Jersey 08812.

## Graduate Lectures in Surgery

Additional programs in the "Distinguished Lecture Series" offered by the Department of Surgery of the New Jersey Medical School (CMDNJ) have been listed as follows:

- |            |  |
|------------|--|
| January 22 | Primary Aldosteronism<br>Richard H. Egdahl, M.D., Professor of Surgery<br>Boston University Medical Center |
| February 5 | Cancer of the Breast<br>George P. Rosemond, M.D., Professor of Surgery<br>Temple University Health Center  |
| March 19   | Acute Respiratory Distress<br>Watts R. Webb, M.D., Professor of Surgery<br>SUNY, Upstate Medical Center    |

The lectures are held at 4 p.m. in the amphitheater, 2nd floor, Martland Hospital, Newark. There is no charge. Guarded parking is available in parking areas "M" at 12th and Bergen Streets. Other lectures will be announced in a later issue. For further informa-

tion, please contact Eric J. Lazaro, M.D., Professor of Surgery, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

### **Surgeons Meet in New York**

From April 1 to April 4, 1973, the American College of Surgeons will assemble at the Hilton and Americana Hotels in New York City. Courses are offered in trauma, electrolytes, gastrointestinal surgery, shock, surgery of children, cancer, endocrine surgery, and surgery of peripheral blood vessels. For a detailed program, write to the American College of Surgeons, at 55 East Erie Street, Chicago, Illinois 60611.

### **Course in Diagnostic Ultrasound**

On April 12 and 13, 1973, a seminar, which will present a brief introduction to the physics of medical ultrasound and to current technology and instrumentation, is offered by Columbia University's College of Physicians and Surgeons. A survey of clinical applications of diagnostic pulse-echo ultrasound will be presented, with emphasis on echoencephalography, echocardiography and ultrasonography.

The discussion of echoencephalography will include detection of midline shifts and estimation of ventricular size. The role of echocardiography in the diagnosis of pericardial effusion, mitral, and aortic valve abnormalities and in the diagnosis of congenital heart disease will be presented. The topic, ultrasonography, will include discussion of ultrasonic imaging in obstetrics and gynecology, ultrasonic imaging in the evaluation of renal and other abdominal masses and organs, as well as discussion of a new application, and ultrasonic imaging of the heart.

For information and application write to Melvin D. Yahr, M.D., Association Dean, 630 West 168 Street, New York 10032.

### **Course in Ocular Tomography**

Columbia University's College of Physicians and Surgeons announces a course (seminar/workshop) in ocular ultrasonic tomography

on April 27 and 28, 1973. Fee is \$100. For details, please write to Melvin D. Yahr, M.D., Associate Dean, at 630 West 168th Street, New York 10032.

### **Course in Neuroradiology**

Columbia University announces a course in neuroradiology at the Columbia-Presbyterian Medical Center April 30 to May 4, 1973, under the direction of Ernest H. Wood, M.D. This is a comprehensive review of diagnostic neuroradiology and is designed primarily for radiologists, neurologists, and neurologic surgeons. Emphasis is placed on basic information used frequently in neuroradiologic diagnosis, especially angiography. One day will be devoted to pediatric neuroradiology. The program includes plain film diagnosis, pneumography, myelography, radiology of the orbits, and neuroradiologic approaches to the solution of specific clinical problems.

Inquiries should be addressed to Melvin D. Yahr, M.D., Office of Graduate Medicine, 630 West 168th Street, New York 10032.

### **Electrophysiology Course at Disney World**

The University of Miami and the American Heart Association are sponsoring a course in electrophysiology May 29, 30, and 31, 1973, at the Contemporary Hotel, Disney World. Tuition is \$150. The physiology being presented will be in the field of cardiology. Each member of the distinguished faculty will receive unknown recordings which will be interpreted "live" at the sessions. Answers will be discussed by moderators. Stress is on a logical interpretation of unknown tracings. Subjects to be covered include the newest concepts in A-V block; reciprocating tachycardias; ventricular versus supra-ventricular arrhythmias; pre-excitation syndrome; hemiblocks; bundle branch block. Discussion between faculty and registrants is encouraged. The unknown recordings to be shown at the meeting will be mailed to each registrant in advance. Accompanying these will be brief clinical data. To register, write to Dr. Louis Lemburg, P.O. Box 875, Biscayne Annex, Miami, Florida.



# MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

- |                 |                |   |
|-----------------|----------------|---|
| <b>December</b> | <b>20</b>      | <b>Academy of Medicine of New Jersey</b>                                    |
| <b>7</b>        |                | <b>John E. Runnells Hospital</b>  |
|                 |                | <b>Berkeley Heights</b>   |
|                 |                | <b>Critically Ill Patient</b>   |
| <b>7</b>        |                | <b>Burlington County Memorial Hospital</b>                                  |
|                 |                | <b>Mount Holly</b>  |
|                 |                | <b>Thrombophlebitis and Thromboembolic Diseases</b>                         |
| <b>13</b>       |                | <b>Academy of Medicine of New Jersey and Bergen Pines County Hospital</b>   |
|                 |                | <b>Bergen Pines County Hospital</b>   |
|                 |                | <b>Paramus</b>  |
|                 |                | <b>Cardiomyopathies</b>   |
| <b>13</b>       |                | <b>Academy of Medicine of New Jersey</b>                                    |
|                 |                | <b>Helene Fuld Hospital</b>   |
|                 |                | <b>Trenton</b>  |
|                 |                | <b>Newer Concepts of Hepatitis</b>  |
| <b>13</b>       |                | <b>Dover General Hospital, St. Clare's Hospital, and Riverside Hospital</b> |
|                 |                | <b>Dover General Hospital</b>   |
|                 |                | <b>Dover</b>  |
|                 |                | <b>Hyperlipoproteinemia</b>   |
| <b>13</b>       |                | <b>Pennsylvania Hospital and New Jersey Academy of Family Physicians</b>    |
|                 |                | <b>John F. Kennedy Hospital</b>   |
|                 |                | <b>Edison</b>   |
|                 |                | <b>Psychiatric Emergencies</b>  |
| <b>13</b>       |                | <b>Fair Oaks Hospital and Academy of Medicine of New Jersey</b>             |
|                 |                | <b>Fair Oaks Hospital</b>   |
|                 |                | <b>Summit</b>   |
|                 |                | <b>Hypnosis in Psychiatry—Clinical Cases</b>                                |
| <b>14</b>       |                | <b>Burlington County Memorial Hospital</b>                                  |
|                 |                | <b>Mount Holly</b>  |
|                 |                | <b>Anticoagulant Therapy</b>  |
| <b>20</b>       |                | <b>Bergen Pines County Hospital</b>   |
|                 |                | <b>Paramus</b>  |
|                 |                | <b>CPC Meeting</b>  |
|                 | <b>1973</b>    |   |
|                 | <b>January</b> |   |
|                 | <b>3</b>       | <b>Academy of Medicine of New Jersey and Bergen Pines County Hospital</b>   |
|                 |                | <b>Bergen Pines County Hospital</b>   |
|                 |                | <b>Paramus</b>  |
|                 |                | <b>Advances in Viral Hepatitis</b>  |
|                 | <b>4</b>       | <b>Academy of Medicine of New Jersey</b>                                    |
|                 |                | <b>Fair Oaks Hospital</b>   |
|                 |                | <b>Summit</b>   |
|                 |                | <b>Drug Addiction</b>   |
|                 | <b>10</b>      | <b>Academy of Medicine of New Jersey</b>                                    |
|                 |                | <b>Princeton Medical Center</b>   |
|                 |                | <b>Princeton</b>  |
|                 |                | <b>Renal Failure</b>  |
|                 | <b>10</b>      | <b>Academy of Medicine of New Jersey and Bergen Pines County Hospital</b>   |
|                 |                | <b>Bergen Pines County Hospital</b>   |
|                 |                | <b>Paramus</b>  |
|                 |                | <b>Medical-Surgical Cardiology Conference</b>                               |
|                 | <b>14</b>      | <b>Academy of Medicine of New Jersey</b>                                    |
|                 |                | <b>Radiology Section</b>  |
|                 |                | <b>St. Barnabas Medical Center</b>  |
|                 |                | <b>Livingston</b>   |
|                 |                | <b>Carcinoma of the Ovary</b>   |
|                 | <b>17</b>      | <b>Academy of Medicine of New Jersey and Bergen Pines County Hospital</b>   |
|                 |                | <b>Bergen Pines County Hospital</b>   |
|                 |                | <b>Paramus</b>  |
|                 |                | <b>Variants of Rheumatoid Arthritis</b>                                     |
|                 | <b>17</b>      | <b>Fair Oaks Hospital and Academy of Medicine of New Jersey</b>             |
|                 |                | <b>Fair Oaks Hospital</b>   |
|                 |                | <b>Summit</b>   |
|                 |                | <b>Proper Use of Antibiotics</b>  |

- |  |   |
|--|---|
| <p>24 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Acupuncture</p> <p>25 Academy of Medicine of New Jersey<br/>and Radiological Society of New Jersey<br/>Hospital Center at Orange<br/>Interesting X-rays of the Month</p> <p>29 Academy of Medicine of New Jersey<br/>New Jersey State Hospital, Aneora<br/>Hammonton<br/>Congestive Heart Failure</p> <p>31 Academy of Medicine of New Jersey<br/>Morristown Memorial Hospital<br/>Morristown<br/>Proper Use of Antibiotics</p> <p>31 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Idiopathic Thrombocytopenic Purpura</p> <p><b>February</b></p> <p>1 Fair Oaks Hospital of New Jersey<br/>Academy of Medicine of New Jersey<br/>Fair Oaks Hospital<br/>Summit<br/>Neurologic Syndromes in Psychiatry</p> <p>7 Bergen Pines County Hospital<br/>Paramus<br/>CPC Meeting</p> <p>14 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Diet and Diseases of the Colon</p> <p>14 Academy of Medicine of New Jersey<br/>Fair Oaks Hospital, Summit<br/>Medical-Surgical Emergency in Psychiatric<br/>Practice</p> <p>15 Academy of Medicine of New Jersey<br/>St. Francis Hospital<br/>Trenton<br/>Respiratory Care</p> | <p>21 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Mechanisms of Antibiotic Activity</p> <p>22 Academy of Medicine of New Jersey<br/>and Radiological Society of New Jersey<br/>Hospital Center at Orange<br/>Orange<br/>Interesting X-rays of the Month</p> <p>24 Academy of Medicine of New Jersey<br/>Hunterdon Medical Center<br/>Flemington<br/>Endotoxic Shock</p> <p>28 Academy of Medicine of New Jersey<br/>and Bergen Pines County Hospital<br/>Bergen Pines County Hospital<br/>Paramus<br/>Electrophysiologic Basis of Cardiac<br/>Arrhythmias</p> <p><b>March</b></p> <p>1 Fair Oaks Hospital and<br/>Academy of Medicine of New Jersey<br/>Fair Oaks Hospital<br/>Summit<br/>Adolescent Psychiatry</p> <p>3 St. Barnabas Medical Center<br/>Livingston<br/>Post Anesthesiology Nursing</p> <p>7 Academy of Medicine of New Jersey<br/>St. Michael's Medical Center<br/>Newark<br/>Proper Use of Cardiovascular Drugs</p> <p>13 Academy of Medicine of New Jersey<br/>Bloomfield<br/>Dermatologic Therapy</p> <p>14 Fair Oaks Hospital and<br/>Academy of Medicine of New Jersey<br/>Fair Oaks Hospital<br/>Summit<br/>Adolescent Psychiatry</p> <p>14 Academy of Medicine of New Jersey<br/>Helene Fuld Hospital<br/>Trenton<br/>Proper Use of Antibiotics</p> |
|--|---|

- |  |  |
|--|--|
| <p>21 Academy of Medicine of New Jersey<br/>Hospital Center at Orange<br/>Radiotherapy of Breast Carcinoma</p> <p>22 Academy of Medicine of New Jersey<br/>and Radiological Society of New Jersey<br/>Hospital Center at Orange<br/>Interesting X-rays of the Month</p> <p>26 Academy of Medicine of New Jersey<br/>New Jersey State Hospital, Ancora<br/>Hammonton<br/>Difficult Diabetic Patients</p> <p>27 Academy of Medicine of New Jersey<br/>Warren Hospital<br/>Phillipsburg<br/>Medical-Legal Aspects in Surgery</p> <p>28 Academy of Medicine of New Jersey<br/>Perth Amboy Memorial Hospital<br/>Perth Amboy<br/>Differential Diagnosis of Jaundice</p> <p>28 Academy of Medicine of New Jersey<br/>New Jersey College of Medicine<br/>Newark<br/>Host Deficiencies</p> <p>28 Academy of Medicine of New Jersey<br/>Morristown Memorial Hospital<br/>Morristown<br/>Treatment of Shock</p> <p>29 Fair Oaks Hospital and<br/>Academy of Medicine of New Jersey</p> | <p>Fair Oaks Hospital<br/>Summit<br/>Adolescent Psychiatry</p> <p>April<br/>4 Academy of Medicine of New Jersey<br/>Newark Beth Israel Medical Center<br/>Newark<br/>Modern Treatment of Cancer</p> <p>11 Academy of Medicine of New Jersey<br/>Rutgers Medical School<br/>New Brunswick<br/>Coronary Artery Surgery</p> <p>11 Fair Oaks Hospital and Academy<br/>of Medicine of New Jersey<br/>Fair Oaks<br/>Summit<br/>Pharmacotherapy of Mental Disorder</p> <p>26 Academy of Medicine of New Jersey<br/>and the Radiological Society of<br/>New Jersey<br/>The Hospital Center at Orange<br/>Interesting X-rays of the Month</p> <p>26 Fair Oaks Hospital and Academy of<br/>Medicine of New Jersey<br/>Fair Oaks Hospital<br/>Summit<br/>Pharmacotherapy of Mental Disorders</p> <p>30 Academy of Medicine of New Jersey<br/>Ancora Psychiatric Hospital<br/>Hammonton<br/>Hypertension</p> |
|--|--|

---

## OBITUARIES

---

### Dr. Anthony Ambrose

Born in 1897, Anthony Ambrose, M.D., died on October 2. He was a 1921 alumnus of Columbia University's College of Physicians and Surgeons. Dr. Ambrose was a well-known, board-certified ophthalmologist and a Fellow of the American College of Surgeons. He had staff appointments at Newark Eye and Ear, Martland, and Clara Maass Hospitals. He

served on the Newark Board of Education from 1962-65. Dr. Ambrose was a member of the Morris County Medical Society and a 1971 Laureate of MSNJ's Golden Merit Award.

### Dr. Abraham Krechmer

Abraham Krechmer, M.D., a former chief of the outpatient department at Atlantic City Hospital, died on October 3, 1972. He had been a general practitioner, interested in geriatrics. In 1951, Dr. Krechmer became disabled with a back injury and retired from active practice. He was a member of the Atlantic County Medical Society and was a pioneer



Fellow of the American Academy of Family Practice. Dr. Krechmer was a graduate of Temple University Medical School, class of 1930, and was 71 years old at the time of his death.

#### **Dr. Maurice M. Lynch**

At the age of 71, Maurice M. Lynch, M.D., died on October 16, 1972. He was a Bergen County surgeon and belonged to that County Medical Society. He was a 1925 graduate of the medical school at the University of Virginia. Dr. Lynch had a long period of service as Chief of Surgery at the Holy Name Hospital in Teaneck and was a Fellow of the American College of Surgeons.

#### **Dr. Lodovico Mancusi-Ungaro**

A 400-year old family medical heritage characterized Lodovico Mancusi-Ungaro, M.D., of Newark, who died on November 4, 1972, at the grand age of 91. A 1906 graduate of Bellevue, he interned at Saint James Hospital in Newark and continued in general practice from 1907 to 1919, when he began limiting his practice to internal medicine. He inaugurated Newark's first cardiology clinic. He was affiliated with the Department of Cardiology at Cornell University Medical School and was on the staff at Martland Medical Center and Saint James Hospital in Newark. Dr. Mancusi-Ungaro was the dean of a large medical family in New Jersey and his ancestors have been physicians in Italy since 1550.

#### **Dr. Alberto Mejia**

At the untimely age of 50, Alberto Mejia died on October 14, 1972. He was graduated in 1952 from the National University of Mexico and became a general practitioner, affiliated with the West Jersey Hospital in Berlin (NJ) and the Kessler Memorial Hospital in Hammononton. Dr. Mejia was a member of our Atlantic County Medical Society.

#### **Dr. Luke A. Mulligan**

New Jersey lost one of its best-known physicians on October 26, 1972, with the death that

day of Luke A. Mulligan, M.D. Born in 1902, he was a 1929 graduate of the Long Island College of Medicine. Dr. Mulligan was on the State Society's Board of Trustees from 1952 to 1963 and was Chairman of the Board during the last half of that decade of service. He was twice appointed to the Hospital Advisory Council of the Board of Control of our State Department of Institutions and Agencies. He was also a director of the Board of Managers of Bergen Pines County Hospital, and was an attending surgeon at Holy Name Hospital in Teaneck. He was chairman of our State Society's Committee on Medicine and Religion, and had been a member and chairman of the Medical Student Loan Committee. For the last five years Dr. Mulligan was one of our Delegates to the American Medical Association.

#### **Dr. S. Emlen Stokes**

One of southern New Jersey's leading practitioners, S. Emlen Stokes, M.D., died on October 9, 1972, at the age of 78. Dr. Stokes received his M.D. at the University of Pennsylvania in 1918, and was a pioneer in American pediatrics. He had been president of the Burlington County Medical Society and served several terms as representative from his district on MSNJ's Judicial Council. He was also a member of the State Society's old Welfare Committee for many years. For 18 years, he was chairman of the Board of Managers of Haverford College, from which he had been graduated with honors in 1914. The science building there is named Stokes Hall in his honor. He had two years' service as Assemblyman from Burlington County, and for a decade was a member of the State Board of Control of our New Jersey Department of Institutions and Agencies. Dr. Stokes had been chief of pediatrics at Burlington County Memorial Hospital in Mount Holly, and attending in pediatrics at Cooper Hospital in Camden, Zurbugg Memorial Hospital in Riverside, and Children's Hospital in Philadelphia. He was a laureate of the MSNJ Golden Merit Award in 1968. Dr. Stokes was, in the best sense of that phrase, an all-around medical citizen.

# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Index



1972

Society established July 23, 1766  
Journal founded September 1, 1901

VOLUME 69

JANUARY TO DECEMBER, 1972

Published monthly under direction of the  
COMMITTEE ON PUBLICATION  
DANIEL B. ROTIL, M.D., *Chairman*

JOHN F. MARSHALL, M.D.  
LOUIS F. ALBRIGHT, M.D.

ARTHUR KROSNIK, M.D.  
MATTHEW E. BOYLAN, M.D.

HENRY A. DAVIDSON, M.D., *Editor*  
MARJORIE D. TREPTOW, *Assistant Editor*

---

Editorial Office  
315 WEST STATE STREET  
TRENTON, N. J.

## HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are listed alphabetically, with an asterisk (\*) to indicate reference to an original article. Editorials are indexed by first significant word of title or by subject; book reviews, by title or subject but not by author. City of residence is indicated for authors of original articles.

If you do not bind your JOURNALS, use the table of pages (below) to find the month of issue to which any page citation refers.

The annual reports of the committees and officers of the Society and the Transactions of the annual meeting appear in the July issue.

## TABLE OF PAGES

January	1 to 86	July	585 to 628 and tr 1 to tr 144
February	87 to 184	August	629 to 708
March	185 to 288	September	709 to 802
April	289 to 398	October	803 to 896
May	399 to 494	November	897 to 988
June	495 to 584	December	989 to 1076
Annual Reports and Transactions		July Journal	

## A

Abortion—Resolution #2 (1972)	688	Altman, Ronald, M.D.	le976
Academic Practice, A Kind Word for—Cross	le177	AMA Councils and Committees, Nominations for	687
Accreditation of Education—Resolution #14 (1972)	688	Membership, Methods to Increase—	
Adams-Ray, Jack, M.D., Stockholm, Sweden	sa859	Resolution #6 (1972)	688
Adoptions	963	Who Needs the?	e601
Adrenals and Chronic Ulcer Disease—Palmer	*455	Ambrose, Anthony	†1063
African Students, Understanding—Anumonye	*1017	American Medical Image, The Other Side of the	e9
Aged, Condescension Medicine for	ab438	Medicine in Crisis	br704
Aging Study, NIMH	ab946	Amphetamine Production Quotas	ab246
Alcohol Act, Proposed Uniform	ab202	Aneurysm, Dissecting, with Spontaneous	
Alcoholic, Is the Doctor Failing the	e506	Recanalization—Corwin; Dolan	*61
Physician's Role in Treating the	e9	Announcements	77, 170, 271, 369, 480,
Alcoholism	ab528		578, 696, 794, 881, 977, 1059
and the Law	br83	Annual Meeting Program (1972)	305
Detection Clinics—Resolution #16 (1972)	688	Reports	tr5
Policy Statement on	262	Anorectal Problems, Common—Swerdlow	*835
Prevention and Early Detection of—Shenkman	*19	Anumonye, Amechi, M.D., Lagos, Nigeria	*139, *1017
Sudden Death and Metabolic Derangement in		Aphakia, Management of—Belmont	*733
—Nevins; Lyon	*155	Apolito, Arnaldo, M.D., Montclair	*943
Aldrich, C. Knight, M.D., Newark	*199	Associate Membership	964
		Attendance—1972 Annual Meeting	625
		Automobile Insurance	781
		Auxiliary President, Our New	e505

1- 86—Jan.  
87-184—Feb.  
185-288—Mar.  
289-398—April

399-494—May  
495-584—June  
tr1-tr144 —July  
585-628  
629-708—Aug.

709- 802—Sept.  
803- 896—Oct.  
897- 988—Nov.  
989-1076—Dec.



## B

Banta, Kurt, B. S., Wayne	*441
Barnard, Christian: One Life	hr490
Barnard, Robert D., M.D.	le78
Baruch, Rudolf J.	†178
Basralian, Joseph B.	†887
Battered Children, Responsibilities for Reporting	473
Bazan, Raul Z.	†982
Becker, George L., Jr., M.D., Franklin Lakes	sa257
Behavior, Surgical Control of	br489
Belmont, Owen, M.D., Philadelphia	*733
Benavente, Carlos	†381
Bergen, Stanley S., Jr., M.D., Newark	*251, *1037
Biologic Rhythms in Human and Animal Physiology	br490
Blood Bank Disaster Plan Manual	ab509
Cultures, Significance of Positive—Burrows; Gottesman	*431
Bloom, G. Homer	†81
Blumenstein, Richard B., M.D., Paterson	*148
Blue Cross-Blue Shield Group Enrollment—Resolution #27 (1972)	688
Cross Blues—Hulett	le700
Bolanowski, Kasimier J.	†700
Bone Cements, FDA Approval of	ab539
Book Reviews	83, 179, 285, 391, 489, 581, 703, 799, 893, 984, 1073
Bookkeeping, Statewide Automated	72
Boughton, Thomas H.	†887
Boutelle, William E.	†283
Bowen, Robert N.	†579
Bradley, Robert A.	†579
Bradycardia-Tachycardia Syndrome—Wartenberg; Haynes	*659
Brain Tumors, Management of—Ross	*517
Breast, Primary Sarcoma of—Kolarsick	*243
Breast Cancer, Multicentric Origin of—Brief; Gopalakrishnan; Kim	*419
Cancer, Preoperative Irradiation of—Sanfilippo	*531
Brief, Donald K., M.D., Newark	*419
Brodkin, Henry A., M.D.	le579
Browder, Ann A., M.D., Newark	*101
Browdy, Sol, M.D.	le281
Brown, Kenneth	†485
Brozdowski, John J.	†796
Bueno, Rolando M., M.D., Jersey City	*1011
Burks, William P., M.D., Princeton	*45
Burrows, Stanley, M.D., Camden	*431, *919
But First, No Harm!	e412

Carmona, L. Roberto	†700
Catangay, Pablo A., M.D., Paramus	*641
Cellular Pathology	br703
Cerebral Palsy, Operative Orthopedics in	br489
Cerebrovascular Insufficiency in the Elderly, Chronic—Rosen	*445
Chandler, James J., M.D., Princeton	*45
Chest Cases, Erroneous Diagnoses on Admission of—Cohen; Bueno	*1011
Screening, Mobile	ab667
Chiger, Alexander S.	†701
Child Abuse, Management of	sa551, 563
Abuse, Management and Follow-up of—Cosgrove	*27
Chinese Art of Healing	br893
Chiropractic	163, 261
Cholecystectomy and Operative Cholangiography—Chandler; Burks; Miller	*45
Chondromalacia in Runners—Sheehan	*527
Chopin, Richard, M.D., Newark	*679
Chylak, Nicholas	†982
Civilian Doctor in Vietnam	br704
Clapp, Richard W., New York	*251
Cohen, Jay A., M.D.	le282
Cohen, Paul	†81
Cohen, Royal M.	†580
Cohen, Samuel, M.D., Jersey City	*1011
Combination Products, Guideline on Therapy	e198
Commissioner Replies, The—Cowan	le379
Committees and Councils—1972-1973	787
Communicable Diseases in New Jersey	76, 166, 263, 362, 472, 565, 693, 783, 878, 967, 1049
Complete Physical, The	e303
Compulsory Re-education, Against—Brodkin	le579
Computerized Literature Searching—Spiegel	sa67
Connolly, Thomas W.	†796
Console, A. Dale	†580
Constitution, Proposed Amendment to MSNJ	267
Cooper, Jules, M.D.	le699
Coronary Care Unit, Psychologic Impact of—Layman	*1001
Care Units, Evaluating Effectiveness of—Goldberg	*541
Vasodilator Efficacy	ab650
Corwin, Norman D., M.D., Westwood	*61, *847
Cosgrove, John G., A.C.S.W., Newark	*27
Courage To Do Nothing	e198
Cowan, James R., M.D.	le379
Coxson, Harold P.	†81
Cross, Richard J., M.D.	le177
Cukier, Daniel S., M.D., Hackensack	*671
Current Diagnosis and Treatment	br799

## C

Cancer, Long Time Survival Rates	1052
Proposed Agency	ab57
Capell, Harry H.	†580
Carcinoma of Lung—Lewis	*927
Cardiac Diagnosis, Long Distance	e815
Cardiology, Self-Study in Clinical	ab23
Cardiovascular Physiology	br799
Career Commitments in Medicine—Bergen	*1037

## D

Dana, Edward	†701
DaSilva, Jacyntho, M.D., Woodbridge	*647
Davis, E. Vernon, M.D., Retiring Address	554
DeAndrade, Ronald	†701
Death After Injuries, Prevention of—Fitts	*211
Decade of Progress: U.S. Medical Department	br799
DeCeuninck, Rene L., M.D.—New Brunswick	*221
Defense of Darvon®—Eli Lilly Company	le699
Delafrange, Kenneth M.	†796

\*—Original Article  
†—Obituary  
ab—Abstract

br—Book Review  
e—Editorial

le—Letter  
sa—Special Article  
tr—Transactions



Manpower, Education of	ab30
Not All Is a Medical Problem	c10
Testing, Automated	ab41
Heartburn—Riegel	*755
Hematology, Introduction to	br1073
Hernia Repair without Disability—Raffman	*651
Hexachlorophene, Misadventure with	c412
Hilton, Clarence O.	†283
Hitschman, Otto B.	†888
HMO's, Caution on	689
Hogan, Marshall D.	†983
Holland, Reuben J.	†888
Holoman, M. Browne	†382
Home as the Place To Die	c640
Care for Bed-Ridden	ab456
Hospitals Must Furnish Free Care	969
Howell, E. Gaylord	†580
Howland, Jonathan	†178
Hulett, Albert G., M.D.	le700
Hunt, G. Halsey, M.D.	le177
Hypercalcemic Crisis in Hyperparathyroidism— Miller; Glover; Nunez	*131
Hyperparathyroidism—Miller; Glover; Nunez	*131
Hypnosis, Society of Clinical	ab839

## I

Icarus and the Physician Pilot	c999
Illnesses of Public Figures	c908
Imipramine and Birth Defects	ab1036
Index	1065
Influenza	263, ab348
Interested Only in Our Profession	c725
Internal Medicine Organizations, Amalgamation of	782
Iron, Learning about	ab246
Ischemia, Slow Blinding by	ab49
Isoniazid: Labeling Changes	ab222

## J

Jackson, Charles H.	†382
Jansen-Liepa, B., M.D., Camden	*743
Jarvis, Daniel G.	†701
Jenkins, Arthur M.	†382
Jones, Granville L., M.D., Summit	*53, *747
Joseph, Julian I., M.D., Wayne	*510
Journal Advertising Rates	468
Subscription Rates	468

## K

Kanengiser, Clifford H.	†701
Karel, Jack R., M.D., Hillside	*159, *413
Kaufman, Jerome G., M.D.	c411, †485
Memorial Resolution	559

Kiley, John E.	†702
Kim, Young M., M.D., Newark	*419
Knauer, Warren H., M.D., American Cancer Society Award	178
Kohn, Norman N., M.D., Cinnaminson	*1035
Kolarsick, Albert J., M.D., Red Bank	*243
Kondo, Shigeo, M.D., Orange	*763
Krechmer, Abraham	†1063
Kunderman, Philip J., M.D., New Brunswick	*437, *927
Kushnick, Theodore, M.D., Newark	*11, *727

## L

L-Dopa Therapy, Mood Changes During— Anumonye	*139
Laryngectomy, Retrained Voice after	ab754
Layman, William A., M.D., Hackensack	*1001
Lasers in Medicine	br703
Lead Poisoning	c99
Poisoning in Newark—Browder	*101
Poisoning in Newark: Erratum	361
Learning, The End of	c197
and Impediments to Learning—Gould	*537
by the Mistakes of Others	c816
Lee, John J.	†81
Legislation: Position on Bills	462, 559, 777
Lempke, Richard J.	†486
Lester, David, Ph.D., Pomona	*665
Let Us Speak with Unified Voice—D'Elia	*507
Letters to <i>The Journal</i>	78, 177, 281, 379, 485, 579, 698, 886, 979
Levine, Sidney C.	†580
Levine, Stephen M., M.D., Camden	*743
Levinson, Louis J.	†702
Levitt, Jesse N.	†283
Levin, Murray, M.D.	le886
Lewin, Leo, M.D.	le380
Lewis, Ralph J., M.D., New Brunswick	*437, *927
Liability Insurance	163, 781
Liaison Committees—1972-1973	790
Lieb, Saul, M.D.	le887
Life Plan Dividends, Increasing	c907
Linke, J. Julian P.	†580
Lipid and Lipoprotein Screening Tests— Shuster; Ramirez; Pribor	*121
Lipshutz, Charles	†81
Literature Searching, Computerized—Spiegel	sa65
Lithium in Affective Disorders—Jones; Estrada	*747
in Psychiatry, Use of	br392
Loavenbruck, Grant, M.S.W., New York	sa345
Lobotomy for Depression and Pain—Winter	*757
Lobsenz, Nathan	†382
Lombardi, Frank L.	†580
Long Term Survival Rate in Cancer	ab1052
Lumbar Disc Disease	br392
Lynch, Maurice M.	†1064
Lyon, Leonard J., M.D., Paramus	*155
Lyons, David R.	†888

\*—Original Article  
†—Obituary  
ab—Abstract

br—Book Review  
c—Editorial

le—Letter  
sa—Special Article  
tr—Transactions



# M

MSP Complaints on Fees	1047
Macpherson, Elwood	†983
Madara, John S., M.D.	1e282
Major Upper Gastrointestinal Bleeding—Weinstein	*933
Malnutrition	br1073
Malpractice Litigation	ab661
Mancusi-Ungaro, Lodovico	†1064
Marano, Michael A.	†797
Marantology?	e304
Marihuana and Health	ab913
Marshall, Edward R.	†983
Martland Administrator	965
Mass Screening of Hereditary Diseases	ab543
Mattikow, Michael S., M.D., Wayne	*441, *753
McCall, Jesse, M.D.—1906-1972	e99, †283
Memorial Resolution	261
McKiernan, Robert L.	†797
Measles and Rubella Immunization	967
Vaccine	783
Mediastinoscopy in Community Hospital—Lewis; Kunderman	*437
Medical Care, New Challenges to—Rogers	*855
College Notes (CMDNJ) 575, 690, 784, 879, 968, 1051	
Diploma of 1820—Saffron	sa684
Education	564
Education, An Innovation in Continuing	sa345
Education and Community Orientation	
Project	163, 263
Interviewing	br893
Journals, Unsolicited	e411
Meetings—Becker	sa257
Microbiology, Review of	br984
Representatives, Professionalization for	ab425
Revolution	ab775
School in South Jersey	780
School's Board of Concerned Citizens	sa773
Student Loan Fund	781
Teams to Deprived Areas	ab849
Medicare Institutional Reimbursement	ab1036
Medicinal Information Center	ab923
Medicine as a Social Science	e99
Meetings of Medical Interest	78, 175, 272, 370, 481, 883, 979, 1061
Megaloblastic Anemia from Starvation Diet—DeCeuninck	*221
Mejia, Alberto	†1064
Melanoma, Surgical Approach to—Wuester	*235
Membership Opinion Survey—Resolution #26 (1972)	780
Meningitis, Aseptic	878
Mental Health Program Report	br703
Health, Separate State Department of	470, 782
Health Centers, Community—Aldrich	*199
Health of the Child	br83
Mentally Retarded, Policy Statement on	
Care of	262, 361
Merselis, John G.	†702
Metabolic Derangement in Alcoholism with	
Malnutrition, Sudden Death in—Nevins; Lyon	*155
Methadone Patients, Pain in	1e485
Miele, Joseph R., O.D.	1e381

Military Medical School	ab1026
Physicians, Higher Pay for	ab738
Miller, David B., M.D. Princeton	*45
Miller, Earle K.	†797
Miller, Edward M., M.D., Englewood	*131
Miller, George M.	†888
Modern Treatment, Vol. 7, #6	br83
Moldaver, Joseph, M.D., New York	sa345
Mood Changes During L-Dopa Therapy—Anumonye	*139
Moolten, Sylvan E., M.D., New Brunswick	*449
Mulligan, Luke A.	†1064
Multiphasic Screening—Burrows	*919
Musulin, N., M.D., Camden	*743
Myloma with Myeloid Metaplasia—Corwin	*847
Myocardial Infarction, Acute Transmural—Haynes	*227

# N

Narcotic Addicts and Newborns—Kushnick; Robinson; Tsao	*727
Antagonist Being Evaluated	ab1006
Antagonists, Search for	ab1039
National Health Insurance, Countdown on—Roth	sa1041
Neumanu, Alfred	†81
Nevins, Michael A., M.D. Paramus	*155
New Jersey Alumni To Remain	ab653
Newborn, Medical Care of Sick	br490
Nickman, E. Harrison	†382
Nitroglycerin Packaging Affects Potency	ab1033
"No Fault" Liability Insurance—Resolution #9 (1972)	688
Nominating Procedure—Resolution #4 (1972)	688
Nonprescription "Sleep Aids"—Kohn	*1035
Nosocomial Infections	br490
Novich, Max M., M.D., Perth Amboy	*841
Nunez, Luis, M.D., Englewood	*131
Nurses in Emergency Departments—Karel	*159

# O

Oberhand, Robert L., M.D., Red Bank	*1023
Obituaries	81, 178, 283, 381, 485, 579, 700, 796, 887, 982, 1063
Obstetrics and Gynecology, Handbook of	br83
Old Age: The Last Segregation	br391
Operative Orthopedics in Cerebral Palsy	br489
Ophthalmia Neonatorum—Zanger; Chopin	*679
Ophthalmology	br490
General	br285
Opinion Survey of Membership—Resolution #26, (1972)	688
Oral Hypoglycemic Drugs	ab756
Organized Medicine and the Democratic Method	e303
Orthopaedic Surgery, Shands' Handbook of	br285
Otitis Media and Tonsillectomy—Adenoidectomy—Wood; Oberhand	*1023
Ovarian Carcinoma, Clinical Center Study	ab259
Enlargements, the Conservative Approach to,—Sweeney	*37
Ownership Statement	971

1- 86—Jan.  
87-184—Feb.  
185-288—Mar.  
289-398—April

399-494—May  
495-584—June  
tr1-tr144 —July  
585-628  
629-708—Aug.

709- 802—Sept.  
803- 896—Oct.  
897- 988—Nov.  
989-1076—Dec.

## P

Pacemaker, New Development	362
Palmer, Eddy D., M.D., Long Valley	*455
Palmisano, Vincent S., M.D.	le379
Passive Infants—Intelligent Youngsters	ab830
Patel, D. R., M.D., Orange	*763
Jayantilal, M.D., Wayne	*510
Pedevill, Joseph R.	†178
Pediatric Diagnosis and Treatment	br1073
Nurse	br799
Nurse Practitioner	964
Therapy	br704
Peguero-Olivo, F., M.D., Philadelphia	*743
Pelligrini, Vincent	†702
Peptic Ulcer	ab553
Periphrenic Abscess with Subphrenic Extension— Joseph; Patel	*510
Perkel, Louis L.	†797
Perlmutter, Irving K.	†486
Perrotta, Anthony J.	†81
Personal Crises, Dealing with	ab521
Peterman, Robert	†382
Physician Assistants' Training—Bergen; Clapp	*251
Education Coordinator	694
Pilot	e999
Physician's Assistant, Current Status of	169
Role in Treating the Alcoholic	e9
Physicians' Assistants	780
Physicians Seeking Location in New Jersey	164, 363, 576, 695, 880, 966, 1057
Physiologic Basis of Training and Conditioning of Athletes—Novich	*841
Chemistry	br581
Physiology of Reproduction	br179
Poisoning, Handbook of	br489
Pollutants	ab1013
Polycystic Liver Disease—Levine; Peguero-Olivo; Musulin; Principato, E.; Liepa; Principato, L.	*743
Pous, Carlos A.	†486
Premarital Examinations—Palmisano	le379
Preventive Medicine in World War II	br285
Pribor, Hugo C., M.D., Perth Amboy	*121
Principato, E., M.D., Haddonfield	*743
L., M.D., Collingswood	*743
Private Practice, Survival of in Prepaid Care— Goldsmith	*767
Proprietaries, A Billion for	e816
Prostaglandins: Drugs of the Future?	e908
Psychiatric Disability, Compensation in	br703
Psychologic Impact of Coronary Care Unit— Layman	*1001
Psychosurgery, the Renaissance of—Jones	*53
Public Relations Projects	781
Publication Committee	468
Pulmonary Edema—Catangay	*641

## Q

Questions Parents Ask About Their Children	br984
--	-------

## R

Radest, Louis J.	†702
Radiation Protection Fee Schedule	782
Safety Standards	ab106
Raffman, Richard A., M.D., Madison	*651
Ramirez, Gonzalo, M.D., Perth Amboy	*121
Reconstruction of External Ear in Children— Bloomenstein	*148
Reference Committees	tr127
Refraction, Future Technics of—Safir	*949
Registration, Physicians Annual	577
Rehabilitation Medicine	br391
Reinhart, Harry A.	†888
Reproduction, Physiology of	br179
Something New in	ab125
Research, Pure and Applied	e1000
Starts with Clinicians	e601
Residential Placement—Cooper	le698
Resolutions	tr106
Memorial	tr105
Resuscitation in Coronary Care Units	ab928
Rheumatoid Hands, Reconstruction of—Spivak	*547
Riegel, Norman, M.D., Paramus	*755
Robinson, Marcy, Newark	*727
Rogers, James A., M.D., Paterson	*855
Rosen, Herbert J., M.D., Dover	*445
Ross, Ira S., M.D., South Orange	*517, le887
Roth, Russell B., M. D., Erie, Pa.	sa1041
Rutgers Medical School, Progress Report	71

## S

Sachs, Miriam	†283
Saffron, Morris H., M.D., Passaic	sa684
Safir, Aran, M.D., New Rochelle, New York	*949
Sandler, Samuel A.	†382
Sanfilippo, Louis J., M.D., Livingston	*531
Schwartz, William	†797
Scientific Exhibits	971, 1053
Scuba Diving	ab676
Sella Turcica in Mentally Retarded— Villaverde; DaSilva	*647
Senior Medical Consultants—Loavenbruck; Moldaver	sa345
Severe Depression Resembling Severe Physical Illness—Apolito	*913
Sewage Disposal from World Trade Center— Resolution #29 (1972)	688
Sex Hormone Levels and Aggressive Behavior	ab115
Shapiro, Albert B.	†797
Sheehan, George A., M.D., Red Bank	*527
Shenkman, Michael, M.D., Westwood	*19
Shuster, Marvin, M.D., Perth Amboy	*121
Sialographic Evaluation of Parotid and Submandibular Masses—Cukier	*671
Sickness, Illness, Disease	e907
Skyjacker, The	br489
Slowinski, Eugene J.	†888

\*—Original Article  
†—Obituary  
ab—Abstract

br—Book Review  
e—Editorial

le—Letter  
sa—Special Article  
tr—Transactions

Smallpox	76, 565
Vaccination Requirements for Foreign Travel	166
Smith, Joseph A.	†702
Social Activist, Physician As a	le380
Solid Waste	577
Spiegel, Isabel, Newark	sa65
Spivak, Jerome, M.D., Irvington	*547
Sports Physician, The	c99
Stewart, David F. R.	†702
Stokes, S. Emlen	†1064
Strauss, Max	†486
Substernal Goiter Associated with Syncope and Stroke—Moolten	*449
Suicide—Lester	*665
Curriculum Available	ab414
Prevention and Crisis Intervention	ab539
Sullivan, Charles J.	†178
Sweeney, Francis X.	†81
Sweeney, William J., III, M.D., New York	*37
Swerdlow, Dave B., M.D., Glen Ridge	*835

## T

TB Isolation Procedure	le282
Talcum Granuloma—Patel; Kondo	*763
Talking Pictures for Patient Contact—Adams-Ray; Garner	sa859
Tarchiani, Lucius	†383
Teeth, Teeth, Teeth	br83
Telephone Consultation Service	ab1022
Teng, Chih, E.	†383
Terminal Illness, If You Had a	c725
Testing Not Enough?	le379
Thrombocytopenic Purpura Following Use of Nonprescription Medication—Kohn	*1035
Thrust, Dialogue, and Nitty-Gritty	c601
Thyromimetic Medication	le78
To Inherit and To Possess—DuVal	sa957
Tomec, Richard C.	†888
Fomkins, William	†486
Tonsillectomy-Adenoidectomy and Otitis Media—Wood; Oberhand	*1023
Transactions—1971 House of Delegates	tr8
—1972 House of Delegates (Index)	tr3
Transplanted and Artificial Organs	ab217
Tree Pollination in Northern New Jersey—Mattikow; Banta; Weiss	*441
Tribute to a True Physician—Madara	le282
Trustees' Minutes:	
November 21, 1971	71
December 19, 1971	163
January 16, 1972	261
February 27, 1972	461
March 19, 1972	469
April 16, 1972	559
May 5, 1972	687
May 9, 1972	687
July 16, 1972	777
September 17, 1972	963
October 15, 1972	1047
Tsao, Carrie, Newark	*727
Tuberculosis	362

## U

Ulcer Disease and Adrenals—Palmer	*455
Urologists' Role in Diabetes Mellitus—Weinberg	*111

## V

VD, How To Wipe Out in One Day—Browdy	le281
Story, The	br391
Vaccines	ab535
Vakili, Rahim	†486
Vanderbeek, Frank B.	†383
Vasectomy—Fadil	*909
Vibrio Parahaemolyticus	1049
Villaverde, Manuel M., M.D., Woodbridge	*647
Viral Cultures Available in New Jersey	le979
Vision Training, A Plea for	le380
Vitamin C and the Common Cold	br285

## W

Wagman, Edward, M.D., Paramus	*817
Warts Are Treatable—Levin	le886
Wartenberg, Martin B., M.D., Princeton	*659
Warwick, Ralph A.	†383
Wasilewski, Victor	†702
Weinberg, Sidney R., M.D., Brooklyn	*111
Weinstein, L. Donald, M.D., Hackensack	*933
Weisman, Herbert W.	†888
Weiss, Irving, M.D., Wayne	*441
Winter, Arthur, M.D., East Orange	*757
Witness Stand, What To Expect on	ab434
Woman's Auxiliary	781
Auxiliary Report—1971-1972	623
Wood, William L., M.D., Red Bank	*1023
Work Addict, The	c725
Wuester, William O., M.D., Elizabeth	*235

## Y

Young, William V.	†383
Your Money or Your Life	br893
Youth in Turmoil	ab143
Yuzan, Florenzio, M.D., Newark	*1029

## Z

Zanger, Norman W., Newark	*679
---------------------------	------

1- 86—Jan.  
87-184—Feb.  
185-288—Mar.  
289-398—April

399-494—May  
495-584—June  
tr1-tr144 —July  
585-628  
/629-708—Aug.

709- 802—Sept.  
803- 896—Oct.  
897- 988—Nov.  
989-1076—Dec.



---

# BOOK REVIEWS

---

**Introduction to Hematology.** William M. Dougherty.  
St. Louis, Mosby, 1972. Pp. 253. Illustrated. (\$10.50)

This poorly organized text is supposed to introduce a student to hematology and then stimulate him into further study of standard texts. It is difficult to understand to what student group it is aimed. Several parts are too complex and detailed for hematology technicians (especially the details of blood proteins and the highly descriptive studies of marrow slides), while much of other material is too simplistic to be aimed at advanced medical students or physicians interested in the field. Its chapter on cell structure in general is superfluous in a book that must assume previous knowledge of the reader.

Several subjects are considered in separate sections, resulting in disjointed presentation and occasional contradictory conclusions. More important, however, are the author's unsubstantiated opinions and presentation of outdated theories or incorrect information. The section on abnormal hemoglobins is full of half truths and misinformation as is the consideration of polycythemia. Even the very liberal illustration fails generally because the black and white photographs (over 250 of them) do very little for understanding how blood looks in the microscope. On the other hand, simplified structural drawings of hemoglobin or iron metabolism, which would clarify lengthy descriptions, were totally absent.

I am sorry to say that this book adds very little to the well-established standard texts in hematology.

Melvin H. Freundlich, M.D.

**Malnutrition: Its Causation and Control,** Vols: I and II. John R. K. Robson, M.D., New York, Gordon and Breach, 1972. Pp. 613. Illustrated. (Price not stated)

This two-volume work is a compilation of 18 years experience of the author and his associates throughout the world. It attempts to answer several basic questions, such as: (1) What is normal nutrition? (2) What nutrients does the body require to maintain health? (3) How do we know if adequate nutrition has been achieved? (4) What are the manifestations of malnutrition? (5) How do we promote better nutrition and relieve existing malnutrition?

The inter-relationship of local environmental conditions, ecologic factors, and physical and emotional considerations within the individual group or person is studied. Included is a discussion of the role played by population; land availability and preparation; the health, education, and numbers of the work force; economic considerations; hereditary and endocrine factors; role of excessive appetite and eating habits.

Deficiency states are defined and discussed briefly, and some are illustrated by photographs. Overnutrition is defined and discussed, and disease states due to toxic substances and malabsorption problems are briefly catalogued.

These books will appeal to students of nutrition, and possibly to the sociologist. However, little value or interest is seen to the practicing physician, whose medical and graduate training encompasses much more than the basic physiologic and biochemical material presented, and whose need for specific dietary counseling problems is not here satisfied.

Joseph Peyser, M.D.

**Current Pediatric Diagnosis and Treatment,** Edition 2. C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D. Los Altos, California, Lange, 1972. Pp. 1008. (Softback \$12)

As a contributing author to a volume designed to compete with this book, I forced myself to read it with objectivity and came away with feelings of jealousy. In spite of a few spelling mistakes and indexing errors this is a superb volume for medical students, interns, residents, and for a practitioner treating children or with children of his own. Of the fifty-one contributors fifty are from Colorado. It must be the mountainous terrain that has enabled this group to produce such a lofty view of pediatrics which is still useful for sea level practitioners.

In the course of the general practice of pediatrics I had occasion to look things up 19 times in a seven week period. I found answers to my problems 16 times and did not find answers three times. There was useful information for me on subjects including hand, foot and mouth disease, mumps, salicylism, speech and language development, pediculosis capitis, pertussis, post-splenectomy infections, and hypoparathyroidism. I had problems related to genetic counseling in epilepsy, infectious mononucleosis, and diphtheria, and in these areas I had to look elsewhere for answers.

The text is readable. The print is legible. The references are superb. The price is right.

Solomon J. Cohen, M.D.

**Drugs of Choice 1972-73.** Edited by Walter Modell, M.D. St. Louis, Mosby, 1972. Pp. 900. (\$21.50)

Seven previous editions certify to the acceptability of *Drugs of Choice*. It includes chapters grouped according to the body systems affected by the medications—chapters on anticonvulsants, diuretics, analgesics, medication for heart disease, and so on. Some 42 experts wrote the 42 chapters. The book includes the well-known "green section" at the end, which, in a single alphabetical listing, covers nearly all the therapeutically useful medications available, with trade name equivalents, dosage forms, and methods of administration. There is a chapter on legal complications, one on general principles of drug choice, one on adverse reactions to drugs, and one on medications for children, in addition to the topical sections. Essentially, this is a book of opinions as well as simple facts, and the authors of the appropriate chapters take responsibility for clearly indicating their opinions.

The reader is not confused by the presentation of highly controversial material, but the several authors do not shrink from indicating when and where they disapprove of some medications. In a sense, the proper business of medicine is medicines, and this book is a practical road map through the jungle of new medications and constantly changing research results. *Drugs of Choice* in this eighth edition will soon earn its shelf space in any physician's library.

Henry A. Davidson, M.D.

**G.P.'s, INTERNISTS, ORTHOPOD  
GENERAL SURGEON,  
PEDIATRICIAN**

Growing H M O adding to staff for two new medical centers to be opened in 1973. Competitive salary, bonus & tax sheltered fringe benefits such as retirement, sabbaticals, etc. Send curriculum vitae to Henry C. Cosand, M.D., Family Health Program, Room 11214, 2925 North Palo Verde Avenue, Long Beach, California 90815.

**NEW JERSEY  
EMERGENCY ROOM  
FULL TIME**

(APPROXIMATELY 3 DAYS PER WEEK)

**ALL SHIFTS AVAILABLE**

**NEW JERSEY LICENSE REQUIRED**

APPLY: R. J. Matthews, Personnel Director, Point Pleasant Hospital, Osborn Ave. and River Front, Pt. Pleasant, New Jersey 08742. Phone (201) 892-1100

**PART-TIME PHYSICIAN**

Jersey licensed physician for Planned Parenthood clinic located at 174 Brower Avenue, Edison, New Jersey. Ob-Gyn preferred. \$25/hour. Call (201) 225-2777 or write: Planned Parenthood, 174 Brower Avenue, Edison, New Jersey 08817.

**PHYSICIANS WANTED:** Psychiatrist—Immediate openings to work on Psychiatric Services. Also openings in community mental health clinics in need of expansion. Jersey Shore Area. Excellent personnel programs and benefits. May have part time practice. State License required. Salary to \$29,-714.00 depending on qualifications. Send resume in confidence to Michael R. Simon, M.D., Medical Director, Marlboro Psychiatric Hospital, Marlboro, New Jersey. Telephone: 201-946-8100.

**DIRECTOR OF MEDICAL RESEARCH  
PLANNING AND OPERATIONS**

Highly successful, large, international pharmaceutical organization has a high level position on medical research staff for an M.D. with strong interest and capabilities in long range planning, control and coordination of widely diversified medical research activities. While prior industry experience is preferred, individuals with background in government, academia or private research foundation considered. Candidate must have broad range of interests with ability to stay continuously abreast of latest developments in clinical research, medical education and regulatory organizations. He will be required to establish and review periodically status of clinical projects informing management of significant deviations from plan. The applicant must have previously demonstrated superior ability to deal with and communicate effectively with high level scientific personnel. Only individuals with outstanding management potential considered. Middle Atlantic suburban location. Base compensation \$40-\$50,000 plus liberal fringe. Confidence of all candidates protected by consultants. Write or call collect:

**PACKARD ASSOCIATES**

3 Water Lane, Manhasset, N. Y. 11030  
516-627-0656

**PSYCHIATRISTS—PSYCHIATRIC  
RESIDENTS**

Immediate full-time psychiatrist positions available. Salary range for full-time staff psychiatrists up to \$34,019, depending upon qualifications and position title. Fully approved residency training positions in psychiatry also available. First to third year Residents stipend from \$12,200 to \$14,200. Modern decentralized psychiatric complex of 1520 beds fully accredited by JCAH with 1:1.1 staff-patient ratio, interdisciplinary approach to patient services, located within easy travel to Philadelphia, New York and nearby seashore resorts. Excellent benefits include low-cost modern family housing, health and life insurance, pension, liberal vacation and sick leave. Write Farrell R. Crouse, M.D., Medical Director, Ancora Psychiatric Hospital, Hammonton, New Jersey 08037. Equal opportunity employer.



# CLASSIFIED ADVERTISEMENTS

**AVAILABLE**—Family physician, in forties, now in research; extensive practice experience, available for coverage or Emergency Room work, weekends, nights; North Jersey, write Box No. 36, c/o THE JOURNAL or call (201) 696-5117.

**AVAILABLE**—Specialty urology, general medicine. Board eligible, prefers industrial medicine South Jersey area. Available January.

**INTERNIST-CARDIOLOGIST WANTED**—Board certified, qualified to associate with Internist-Cardiologist and Gastroenterologist in Northern New Jersey for July 1973. Curriculum vitae with reply. Write Box No. 37, c/o THE JOURNAL.

**INTERNIST NEEDED**—Kinnelon, New Jersey, will share furnished office and secretary. Rent \$200 per month. Kinnelon Medical Center located in beautiful Northern New Jersey. Phone (201) 838-0188.

**INTERNIST WANTED**—To join three-man internist corporation in Northwest New Jersey, no investment, all benefits, send biography to Box No. 32, c/o THE JOURNAL.

**GENERAL PRACTITIONER WANTED**—To associate in active practice, Toms River. Excellent opportunity, good hospital affiliation. Reply P.O. Box No. 4612, Island Heights, New Jersey 08732.

**PEDIATRICIAN**—Board certified, seeks to join other pediatrician or group leading to partnership. H. Lilienfeld, M.D., 432 College Parkway, Rockville, Maryland 20850. (301) 762-0985.

**HOME-OFFICE FOR SALE**—Maplewood, walking distance to schools, corner location with office entrance main street; home entrance side street. On-street parking, easily accessible by all transportation. Central 2-zone heating/air conditioning; automatic garage doors, dog run; 4 bedrooms, 2½ baths; finished basement, den, L-shaped living-dining rooms, modern kitchen. Office suite; waiting room, 3 examination rooms, consultation-examination room, emergency room, nurses station, laboratory, lavatory. Call (201) 763-6813 evenings.

**FOR RENT**—Elizabeth, New Jersey. Fully equipped medical office, retiring due to illness. Option to buy entire home. Call evenings (201) 273-0633.

**OFFICE SPACE**—Cranford, New Jersey, 1000 square feet suites available to lease or purchase in new professional building under construction. Designed to your needs. Write Box No. 34, c/o THE JOURNAL.

**OFFICE SPACE**—Hohokus, New Jersey, 4000 square feet of office space, ideal for medical building. Parking available. Call Doctor Jesse Gurland, (201) 568-4010.

**Information for Advertisers—RATES:**—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifth of preceding month.

## Additional Personnel Needs—See Page 1074

### **SOUTH ORANGE OFFICES PHYSICIANS!**

Lease with or without purchase option—800 sq. ft.—on site parking. Combination Home-Office. Central location; air conditioned; immediate occupancy.

Call

**RAYMOND CONNOLLY CO., REALTORS**  
60 Taylor Pl., South Orange  
(201) 763-0405

### **CALDWELL, N. J.**

Priced for quick sale in the 50's. Ideal for medical practitioner who desires home containing separate professional offices with ample on and off-street parking. Beautiful home, 4 bedrooms, 3 powder rooms, modern kitchen, formal dining room, large living room, + much more.

**PAUL DE BELLIS**  
**EXCLUSIVE BROKER 226-4332**



# Upjohn's low-priced erythromycin



**E-Mycin<sup>®</sup>**  
(erythromycin, Upjohn)  
Available in 250 mg tablets

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

© 1972 THE UPJOHN COMPANY JA72-2141-6



A Joyous Christmas to our friends  
in the Medical Profession  
who make Blue Shield possible...



**BLUE SHIELD**

Medical-Surgical Plan of New Jersey

# Librium® and (chlordiazepoxide HCl) concomitant use

Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, anti-hypertensive agents, diuretics, anticholinergics and antacids.

**Antianxiety effectiveness:** Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling

are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable appropriate levels.

**Effect on mental acuity:** Usually minimal on proper maintenance dosage.

**Safety:** An excellent clinical record. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

LIBRARY  
DEC 14 1972  
NEW YORK ACADEMY  
OF MEDICINE

**in relief of clinically  
significant anxiety**

## Librium® (chlordiazepoxide HCl)

**5-mg, 10-mg, 25-mg capsules  
up to 100 mg daily in  
severe anxiety**

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debili-

tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. Tolerable in most instances by gradual adjustment, but are also encountered at the lower dosage. Also encountered are skin eruptions, edema, irregularities, nausea and extrapyramidal symptoms (decreased libido—all infrequently controlled with treatment; changes in EEG pattern; blood dyscrasias, agranulocytosis), jaundice, liver function tests advised during therapy.

**Supplied:** Librium® capsules 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets 5 mg or 25 mg chlordi-



Roche Laboratories  
Division of Hoffmann-La Roche  
Nutley, N.J. 07110

New York Academy of Medicine  
2 East 105th Street  
New York, New York 10029 C





*The New York Academy of Medicine*

**DUE IN TWO WEEKS UNLESS RENEWED**

NOT RENEWABLE AFTER 6 WEEKS

[illegible]





